A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAM ON AWARENESS OF QUALITY OF LIFE AMONG ELDERLY CARDIAC PATIENTS IN GKNM HOSPITAL, COIMBATORE

Reg No: 30121304

A DISSERTATION SUBMITTED TO THE TAMILNADU Dr. M.G.R. MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT OF REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

April 2014

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CERTIFICATE

This is to certify that the dissertation entitled **A STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAM ON AWARENESS OF QUALITY OF LIFE AMONG ELDERLY CARDIAC PATIENTS IN GKNM HOSPITAL, COIMBATORE** is submitted to the Faculty of Nursing, The Tamil Nadu Dr.M.G.R Medical University, Chennai. It is the bonafide work done by **Reg: No.30121304** in partial fulfillment of the requirement for the award of the degree of Master of Science in Nursing, Branch-I Medical Surgical Nursing, Sub Specialty - Cardiovascular and Thoracic Nursing, during the academic year 2013-2014.

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ABSTRACT

Statement of the Problem: A Study to Assess the Effectiveness of Structured Teaching Program on the Awareness of Quality Of Life among Elderly Cardiac Patients at G.K.N.M Hospital, Coimbatore. **Objectives: 1.**To assess the quality of life of elderly cardiac patients. **2.** To assess the effectiveness of structured teaching program. **3**. To find the association between the pre- test level of scores and selected demographic variables. **Research Design**: Pre- Experimental, One Group pre-test post-test design **Settings:** Cardiac and Cardio – Thoracic Out-Patient Departments and Master Health Department, GKNM Hospital. **Conceptual Framework:** The modified Imogene King's Goal Attainment Model was used. **Samples:** 40 elderly cardiac patients. **Sampling Technique:** Non-Probability Convenient Sampling technique **Methodology:** A self-instructional module was used to collect the data. The pre-test level of awareness on quality of life was assessed using modified WHOQOL-BREF scale and a structured teaching for about 30 minutes regarding, exercise, nutrition, sleep, medication safety, alternatives ways to alleviate pain, skin protection, social wellness, cognitive well- being, psychological well- being, emotional health, safety measures and environmental health was given on an individual basis, and the post-test was collected on the next consequent visit by using the same questionnaire. **Results:** Descriptive and inferential statistics were used to analyze the data and the results showed that there was a significant difference between the pre-test and the post-test level of awareness on quality of life. The overall mean difference was 36.15. the awareness on quality of life was tested by paired 't' test and the results were highly significant at 't' <0.05. These findings indicated that the Structured Teaching Program was effective in creating awareness on quality of life among elderly cardiac patients. **Conclusion:** The findings of the study revealed that the elderly cardiac patients receiving the structured teaching program had a better awareness on quality of life. Hence this teaching program can be implemented by the nurses in cardiac and cardio-thoracic and master health departments, on a regular basis.

CHAPTER – I

INTRODUCTION

"It's not how old you are, it's how you are old
Live your life and forget your age"

-Miller (2007)

Older adults recognize that they have less time in which to continue achieving their goals, so they face their challenges with resilience and determination. Gerontologists are increasingly recognizing that older adults who are aging successfully possess wisdom, which includes factual knowledge, problem- solving strategies, and the ability to manage uncertainty. Because many of the challenges of older adulthood involve health and functioning, older adults need accurate information, not only about aging, but also about interventions to promote wellness. Nurses are ideally positioned to teach older adults about health and aging and empower them to implement problem-solving strategies directed towards wellness, improved functioning, and quality of life **(Blazer., Brugman., 2006).**

With increases in life expectancy, delayed onset of morbidity, and higher expectations for old age, interest in well-being in later life and how to achieve it has intensified. 'Successful ageing' has come to the force as a goal for the ageing population. While an agreed definition of successful ageing remains elusive, there is broad agreement that core constituents include physical health and functioning, psychological wellbeing, and social functioning and participation. As the older population urges both in absolute and relative numbers, well-being in old age has also become a focus for policy-makers as a key indicator of the physical and psychological health, social integration and economic security of the older community **(Bowling A., Dieppe P., 2004).**

Despite the adverse changes that occur with increasing age, older people typically report high levels of well-being. Most feel younger than their actual age and maintain a sense of confidence and purpose. In the Health and Social Services for Older People surveys of older people in Ireland, conducted in 2000 and 2004, over three-quarters of community-dwelling older people scored high on morale **(Garavan R., et al 2001).** In fact, older people are more likely to report satisfaction

with their lives than younger people **(Strine TW., Chapman DP., 2008)**. Old age, it appears, brings with it an ability to adapt to age- related changes and stresses. One study found, that physical decline did not have an impact on older people's satisfaction with life, suggesting that they regard it as a normal and relatively acceptable as part of ageing **(Steverink N., 2001).** Moreover, older people recognize benefits in old age, such as increased wisdom and maturity, with opportunities for growth and lessening of demands upon them. Research has come to emphasize that ageing is highly specific to each individual, which implies that the pathway of old age is not predetermined. While growing older unavoidably entails losses, some individuals cope better with these losses than others. With this in mind, it aims to shed some light on the personal, material and social circumstances that influence how well people cope.

"Successful ageing" refers to those cases where ageing people are free of (acute and chronic) diseases, do not suffer from disability, are intellectually capable, possess high physical fitness and actively use these capacities to become engaged with others and with the society they live in. Concepts which have been used in gerontological research and which emphasize different aspects of the ageing process are healthy ageing **(Ryff., 2009)**

Gerontology has seen many different conceptions of active ageing. A classic definition of active ageing was that "they define successful ageing as the low probability of disease and related disability, high physical and cognitive functional capacity, and active participation in life" **(Rowe & Kahn., 1997).**

There is a strong normative element in the definition of successful ageing. Successful, healthy and productive ageing are evaluated as the more desirable as "normal" or even "pathological" ageing processes. Most people want to grow old without being affected by chronic illnesses and functional disabilities. Despite the efforts are to increase the proportion of healthy life expectancy, a substantial part of the old, and the very old population will have to face dependency and frailty. Hence, attention have to be paid to the fact that normative definitions of "active ageing" should not lead to the degradation and a discrimination against individuals and groups who do not reach the positive goal of "active ageing". **(Fernández-Ballesteros, 2008).**

The WHO definition of active ageing was more inclusive in respect to different ageing trajectories and the diverse groups of older people: "Active ageing is the process of optimizing the opportunities in health participation and security in order to enhance the quality of life of the older people" **(WHO., 2002)**

The Madrid International Plan of Action on Ageing, the UNECE members express their commitment to enhance the cultural, social, political, economic participation of the older people and also to promote the integration of older people by encouraging their active participation in the community.**(UNECE., 2002).**

Old age often bring decreasing functional capacity and health problems which may affect the individual's sense of wellbeing. The goals of health for the older people in the society is that they may not be free from diseases but for having a good life despite of illness are in the decreasing capacities **(Lawton., et al 1991).**

The Quality of life of the people in a developed country with chronic health condition will have a lower impact rather than the patients with the same disease in a low income country where the resources to ameliorate the disability may be scarce.

The subjective and the contextual nature of Quality of life inform the World Health Organization's definition as: "an individual's perception for his/her position in the life in context of culture and the value systems in which he/she live, in relation to his/her goals, standards, concerns and expectations" **(The WHO QUALITY OF LIFE Group., 1995).**

Thus Quality of life reflects an extended view of subjective wellbeing and life's satisfaction that encompasses physical and mental health, interpersonal relationship, and material wellbeing, personal development, work and activities within the communities, and fulfillment and active recreation **(Niemi.,et al 1988).**

There is an important consideration in finding the factors that are associated with the Quality of life of the elderly persons in a multi-dimensional nature of construct and the possibility to determine from one dimension may be different from those that of the other dimension**. (Patel., et al 2007).**

NEED FOR THE STUDY

Little is known about factors that determine the Quality of Life of the elderly persons living in the developing societies and who are undergoing rapid social changes. Quality of life has become increasingly important as an outcome in medical research. The influence of health status is often emphasized, but other dimensions are important. In order to improve quality of life, there is a need to know what people themselves consider important to their perception of quality of life. The studies that are conducted among the groups of elderly persons have shown that Quality of life and the subjective evaluation of the life satisfaction are determined by several factors **(Jakobson., et al 2007).** Other than the demographics such as age and the income, the health, including social support, functional disability and other networks are often found to be important in the elderly person's assessment of their Quality of life. **(Bowling., et al 2005).**

Other than functional impairments and the health problems to which most of the older adults are vulnerable **(Clark and Siebens., 1993),** old age may also predispose to some social and economic problems. The access to health care facility is extermely limited both by manpower and paucity of health facilities and by out-of-pocket payment arrangement. Traditional family support is decreasing and social network is dwindling as migration and urbanization take the young members of the family away. Social changes are also affecting the elderly's position in the society leading to a reduction in their influence and their social status in their community **(Gureje and Oyewole., 2006)**. All of these factors affect the Quality of life of elderly. **(Hickey., et al 2005)**

Quality of life is the central concepts in the ageing research. Two different traditions can be distinguished in this respect: Concepts which define quality of life in terms of objective living conditions, and concepts which define quality of life in terms of subjective evaluation. Similar distinctions have been made in the context of social gerontology **(Noll., et al 2010).**

Erikson., et al (1974) said that the objective quality of life can be measured by the extent to which the elderly has access and command over the relevant resources like income, health, social networks, and competencies that serve the individuals to

pursue their goals and direct their living conditions. Hence, objective quality of life is high in those cases where the health is good, income is high, social networks are reliable and large and the competencies as achieved by the educational status are high. Objective quality of life can be measured by the external observers**.**

Subjective quality of life, in contrast, emphasizes an individual's perceptions and evaluations. Individuals compare their (objective) living situation according to different internal standards and values. That means the elderly people with different aspiration levels may evaluate the same objective situation differently. Subjective quality of life depends upon the individual person – and lies in the "eye of the beholder"**.** Hence, high subjective quality of life can be defined as subjective well-being (high life satisfaction on, strong positive emotions like happiness, and low negative emotions like sadness) **(Campbell, Converse & Rodgers., 1976).**

Quality of life has become increasingly important as an outcome in medical research. The influence of health status is often emphasized, but other dimensions are important. In order to improve quality of life, there is a need to know what people themselves consider important to their perception of quality of life. The study was of 141 randomly selected people aged from 67 to 99 years that formed a control sample for a study of suicide among older people. They were interviewed in person about their health, socio-demographic background and, using an open-ended question, what they considered to constitute quality of life. Their answers were grouped into eight categories. In addition, they were asked to choose from a 'show card' three items that they regarded as important to quality of life. Functional ability was the most frequently selected domain, followed by physical health, social relations and being able to continue to live in one's present home. It was found that social relations, functional ability and activities influence the quality of life of elderly people as much as health status. **(Katarina Wilhelmson., Christina Andersson, et al 2004)**

Since 1970s cardiovascular diseases are the leading cause for the deaths worldwide, cardiovascular mortality rates have been declined in many high-income countries Age is one of the important risk factor for developing cardiovascular diseases, though it usually affects the older adults. It was revealed that 87% of elderly people who die of coronary heart disease are 60 years of age and older. "It's also important that this vulnerable group of people should be looked forward so that they

are assessed and they will receive the best treatment for improving their quality of life." Newcastle University, British Heart Foundation, **(Bernard Keavney., 2012)**

A study was recently carried out 376 heart scans called echocardiograms on 87-89 year elderly persons in their homes. Results revealed that a quarter had undiagnosed heart problems and are missing out on treatments, which could improve their symptoms and their quality of life**. (Bernard Keavney., 2012).**

The purpose of the present study is to identify the effectiveness of structured teaching program on awareness of quality of life among elderly patients with cardiac disorders, at GKNM Hospital, Coimbatore. The researcher strongly believes that, the result of the proposed study can be used to enhance nursing initiatives, and to establish a teaching strategy for elderly patients attending cardiac and cardio thoracic OPD's at GKNM Hospital and thereby improve their quality of life.

STATEMENT OF THE PROBLEM

A Study to Assess the Effectiveness of Structured Teaching Program on Awareness of Quality Of Life Among Elderly Cardiac Patients in G.K.N.M Hospital, Coimbatore.

OBJECTIVES

1. To assess the quality of life of elderly cardiac patients
2. To assess the effectiveness of structured teaching program
3. To find the association between the pre- test level of scores and selected demographic variables

OPERATIONAL DEFINITIONS

Effectiveness: It refers to the outcome of the planned teaching program in terms of awareness gained

Structured Teaching Program: It refers to the systematic information provided to the elderly cardiac patients regarding quality of life.

Awareness: It is the state or ability to perceive, to feel, and a cognitive reaction to the information provided.

Quality of life: It is the personal satisfaction with the cultural or intellectual conditions under which a person lives.

Elderly cardiac patients: Patients above 60 years of age and having cardiac disorders.

HYPOTHESIS

H0: There will be no significant difference between the pre-test and the post-test awareness scores of elderly cardiac patients regarding quality of life.

H1: There will be significant association between the demographic variables and the pre-test awareness scores of elderly cardiac patients regarding quality of life.

ASSUMPTIONS

- The elderly cardiac patients will not have adequate awareness regarding Quality Of Life.
- The structured teaching program will enhance the quality of life of elderly cardiac patients.

CONCEPTUAL FRAMEWORK

Conceptual framework or a model is made up of concepts which are mental image of a phenomenon. These concepts are linked together to express the relationship between them. A model is used to denote symbolic representation of the concepts.

The conceptual framework for this study is based on "Theory of Goal Attainment" by Imogene King the theory focuses on the relationship between the nurse and the patient. It explains how the nurse – patient relationship can influence goals that are set and their level of achievement through transaction process model. The main components of the model are interaction and transactions which are directly observable.

The researcher adopted this theory as a basis for conceptual frame work, which is aimed to find out the effectiveness of structured teaching on awareness on quality of life. This involves interaction between the nurse and the elderly cardiac patient.

PERCEPTION:

It is a process in which the data is obtained through the senses and from memory which are organized, interpreted and transformed. It is not observable but can be inferred. In this study, the elderly cardiac patients have less awareness about quality of life. The researcher's perception is that, the elderly patients have inadequate health maintenance due to the lack of awareness on how to lead a good quality of life

JUDGEMENT:

It refers to the evaluation of the perception to make a decision to take action. Both the researcher and the elderly cardiac patients decide to have a structured teaching program on quality of life to create awareness and to improve the overall health.

ACTION:

Action refers to mental or physical activity to be achieved. In this study, action refers to the plan for assessment on quality of life among elderly cardiac patients using WHOQOL – BREF scale.

REACTION:

Reaction refers to the consequences or results of the action. In this study the reaction is the plan to implement structured teaching program by using flip charts.

INTERACTIONS:

It is defined as the observable verbal and non-verbal goal directed behavior and includes communication, perception and judgment. In this study, the elderly patients having cardiac disorders interact with the researcher for a good quality of life.

TRANSACTION:

It is defined as the process of interaction between two individuals when the six elements are present such as communication, perception, judgment, action, reaction, and interaction. In this study, in order to attain the goal, the researcher and the patient mutually set goals collaborating all the six elements of transactions by assessing the quality of life.

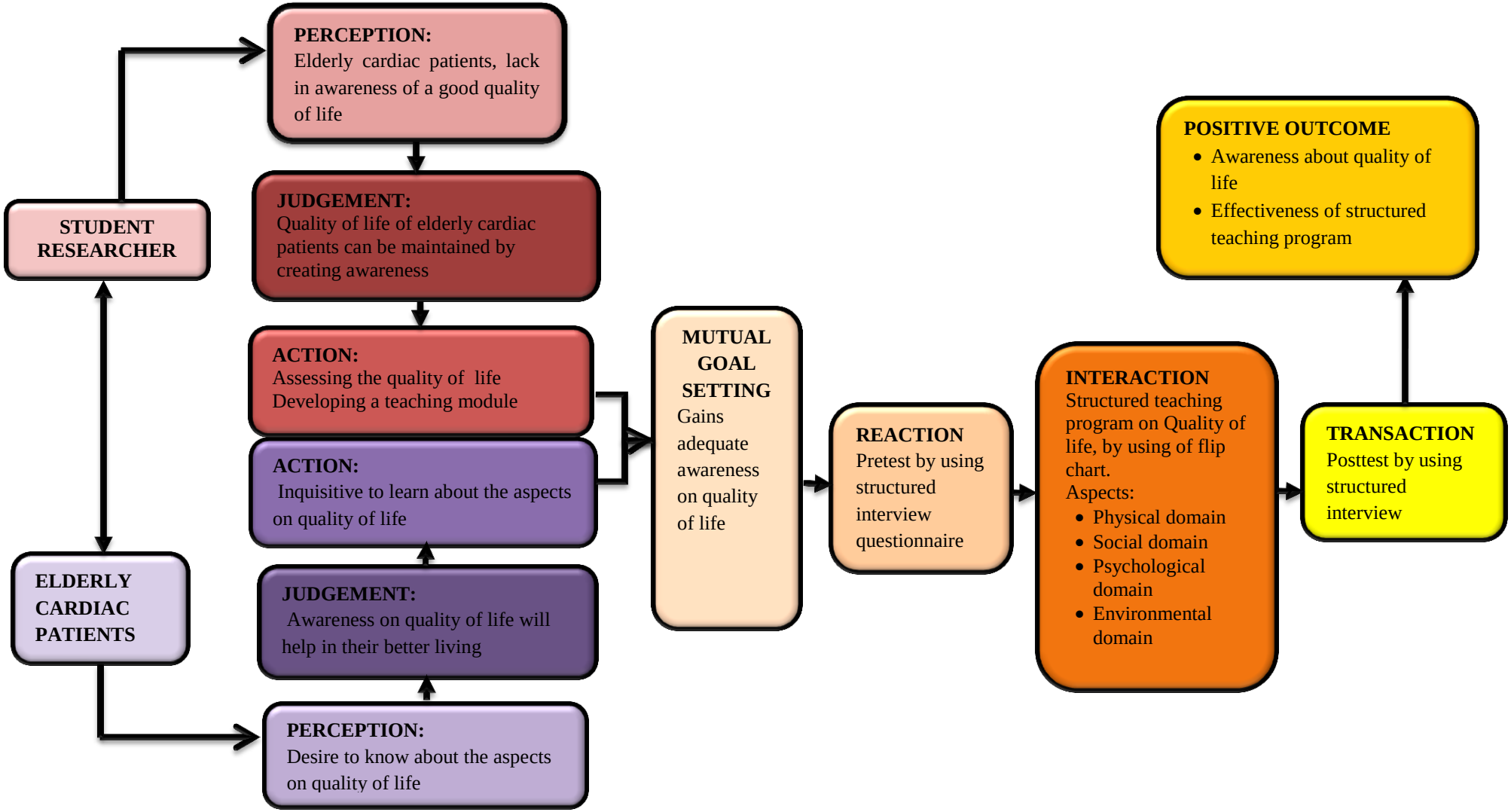


FIGURE: 1.1 - MODIFIED IMOGEN KING'S GOAL ATTAINMENT MODEL

CHAPTER-II

REVIEW OF LITERATURE

Review of literature is a systematic search of published work to gain information about a research topic (Polit, 2008). An extensive review of literature was done by the investigator to lay a broad foundation for the study.

The review of literature is divided into:

Section A : Quality of Life among Elderly Patients

Section B : Elderly and Physical Health

Section C : Elderly and Psychological Health

Section D : Elderly and Social Relationship

Section E : Elderly and Environmental Health

SECTION A: QUALITY OF LIFE AMONG ELDERLY PATIENTS

Shapira OM., et al (1997) conducted a study on the prognosis and quality of life after the valve surgery in the patients who are older than 75 years. A clinical outcome of 147 consecutive patients, who were older than 75 years and who underwent valve surgery between the year of 1992 and 1995 were reviewed. Long term Quality of life was assessed using the modified version of duke university medical outcome study system. The selected patient population and the valve surgery in the elderly are associated with acceptable early morbidity and mortality was taken for the study. The long-term survival and the quality of life were excellent. These facts strongly support the performance of the procedures in elderly patients who are older than 75 years.

G I Kempen., et al (1997) conducted a study on the effect of eight chronic medical conditions on the health related Quality of life. The study analyzed the impact of the eight common chronic medical conditions on the functional, social, and the affective domains of the health related Quality of life among the community based Dutch elderly's health related Quality of life were measured with the six domains, the

MOS short-form, general health survey. Compared with the other domains of the health-related quality of life, the mental health was least affected by the chronic medical conditions and back problems and rheumatoid arthritis and other joint problems accounted for relatively high proportions of the variance in the health related Quality of life and except for the health perceptions, indicating that the health related Quality of life is the most affected by two conditions. Subjective well-being is by far and is the least affected domain affected by chronic medical conditions, while the physical functioning and the health perceptions are the most affected, back problems and rheumatoid arthritis and other joint complaints affected health related Quality of life strongly.

Covinsky KE., et al (2008) conducted a study on the health related Quality of life following the coronary artery bypass graft surgery in the post-menopausal women. One hundred and thirty-seven women who had CABG surgery were enrolled. Following CABG surgery in the post-menopausal women, on an average the health related Quality of life is identical to the preoperative baseline data. However, there is a significant variability; as such the substantial numbers of women are neither significantly better nor significantly worse.

Markus Krane., et al (2010) conducted a study on Quality of life among patients undergoing trans-catheter aortic valve implantation. A prospective analysis of 99 patients who were aged 82 years underwent the TAVI for the assessment of Quality of life, the short form 36 health survey questionnaire was used pre-operatively and also 3 months after the TAVI. Corresponding to the results, the physical health score was significantly increased 3 months after TAVI compared with the preoperative score, whereas the mental health score showed no changes. The conclusion is that in patients who were not eligible for the conventional aortic valve replacement, TAVI leads to a considerable QoL improvement within 3 months after valve implantation.

ZHANG Qiu., et al (2010) conducted a study on the effect of blood glucose control on the quality of life in older persons with type-2 diabetes. The study was performed to determine the effects of glucose control therapy on the Quality of life of the older persons with type-2 diabetes. Ninety seven elderly patients with type-2 diabetes were randomly assigned to the standard treatment group and the intensive

therapy group. All patients had follow- up for about five years on average. No significant difference was seen in all the dimensions of quality of life, as well as in the visual analog scale score between the two groups. It was concluded that the anxiety is common in the older diabetic patients and they experienced frequent hypoglycemic episodes. The diabetic vascular complications significantly affect the Quality of life of the elderly patients. Intensive glucose control had significant effects on Quality of life of the elderly diabetic patient's. Females, older age group, long disease course, less educational status and high BMI, all these factors caused reduced Quality of life and patients with those factors should be given more psychological support.

Upendram Srinivas-Shankar., et al (2010) conducted a study on the effects of testosterone on the muscle strength, physical function, body composition, and the Quality of life in the intermediate-frail and the frail elderly men. It was a randomized, double-blind, and a placebo controlled study. The objective of the study was to determine the effects of 6 months T- treatment in the intermediate-frail and the frail elderly men, on the muscle mass, strength, physical function, and the quality of life. The participants were community-dwellers and were 65 years of age; two hundred and seventy-four participants were randomized to the transdermal T-treatment or placebo gel for 6 months. The conclusions was that the T-treatment in the intermediate-frail and the frail elderly men with low to borderline levels were prevented from age-associated loss of lower limb muscle strength and had improved body composition, physical function and quality of life.

Barutcu CD., et al (2013) conducted a study to find the relationship between the social support and the quality of life in elderly patients with heart failure. Cross-sectional study was carried out at the cardiology out-patient departments in two university hospitals between the month of January and September 2010. Convenient sampling technique was in the study. It comprised of 150 patients who were assessed with a 12-point multidimensional scale for perceived social support, and a 36-point left ventricular dysfunction Scale. The quality of life of the elderly patients improved with the increasing social support. Defining and improving the family and other social support for the elderly patients with heart failure should be a vital part of nursing practice.

Deutsch MA., et al (2013) conducted a study on health related quality of life and the functional outcome in elderly cardiac surgical patients aged 80 years and above. The study was done to evaluate the health related quality of life in elderly undergoing cardiac surgery. A prospective analysis was done on 106 elective elderly patients who were undergoing cardiac surgery. The standardized SF-36 health survey questionnaire was answered pre-operatively, and in the third and in the 12 month post-operatively. Physical health related quality of life was significantly improved in elderly patients in three months after the cardiac surgery and remaining stable in one year postoperatively when compared to the baseline.

Najafi M., et al (2013) conducted a study on the factor structure of the WHO's Quality of life BREF Questionnaire in elderly patients with coronary artery disease. It consisted of two hundred and seventy five patients aged between 35 to 80 years old who were diagnosed of CAD were taken for the study. The Quality of life was assessed and the exploratory factor analysis was performed by the method of vari max rotation. The findings are suggested that the WHOQOL-BREF scale can only be used to measure the overall Quality of life in elderly patients with coronary artery disease, and is not a suitable for measuring the different Quality of life dimensions as expected in the population.

Bang J S., et al (2013) conducted a study on the mental health and the quality of life of the older adult patients with congenital heart diseases. The Quality of life of the older adults with congenital heart disease had gained significant interest. In addition to the medical problems, many older patients with congenital heart disease face educational, psychosocial and behavioral challenges. Eighty five patients were enrolled in the study. They underwent a Quality of life, Beck Depression Inventory survey. The scores were compared with those with the age and the gender-matched population data according to the degree of the underlying congenital heart disease. The severity had a detrimental impact when measured in terms of poor functional status and the initial diagnosis and the course of the illness influences Quality of life and the perceived health, good psycho-social adaptation could be the result of close family relationship and involvement, making the mental adjustments easier.

G.Pierides K. Mattila., et al (2013) conducted a study on the change in Quality of life in older patients undergoing open inguinal hernia repair by assessing

the operational benefits versus the risks in the group of older patient's merits research. In both the groups, the preoperative and postoperative quality of life data were compared statistically within the age categories. Immediate complications were then recorded. The dimensions like physical functioning and pain were significantly improved in the elderly and below 65-years old elderly's. Physical, social and role functioning showed improvement. There was no statistical difference in complication rates that was found across age groups, and so it was concluded that elderly who underwent inguinal hernia surgery showed improved quality of life in physical and social dimensions.

SECTION B: ELDERLY AND PHYSICAL HEALTH

Richard A. Washburn., Kevin W. Smith., et al (1993) conducted a study on physical activity scale for elderly (PASE): Development and evaluation. It was evaluated in a sample of community dwelling elderly people. They were randomly assigned to complete the PASE by e-mail or by telephone before or after the home visit assessment. As hypothesized the PASE scores were positively associated with the grip strength, the static balance and leg strength which negatively correlated with the resting heart rate, the age and the perceived health status.

Allison M., Keller C., et al (1997) carried out a study on the physical activity in the elderly regarding the benefits and intervention plans. In spite of the evidence that the physical activity is valuable, only 30% of the individuals over the age of 65 reported exercising regularly. Regular physical activity can minimize and also prevent the chronic problems and increase the functional ability in the elderly. Planning the physical activity for the older adults requires an initial assessment of the functional ability, the exercise tolerance, the physical limitations, and psychological and social support of the individuals. The exercise prescription should address the intensity, frequency, and the duration of exercise. Several factors also affect the elderly's initiation and adherence to the physical activity program. These include the elderly's perception of factors preventing the physical activity, individual goal setting, and the personal and therapist support in effort.

Paul Montgomery., Jane A Dennis., et al (2002) conducted a study on the physical exercise for the sleep problems in adults aged 60 years and above. One trial

which included 43 participants with insomnia, examined the effectiveness of the exercise in the population within an elderly population. The post treatment sleep onset latency was improved slightly for both the men and the women. The total sleep duration, the sleep onset latency and the scores on a scale of the global sleep quality showed significant improvement. Exercises, though appropriate for all this population, may enhance the sleep and contribute to an increased Quality of life.

Robert J. Nied., Barry Franklin., et al (2002) conducted a study on promoting and prescribing exercise for the elderly. The exercise prescriptions consist of three components they are aerobic exercise, strength training, flexibility and balance. The physicians play a key role in motivating the elderly patients and advising them regarding their physical limitations and their co-morbidities. Regular exercises have been showed to decrease the mortality and the age-related morbidity in elderly patients. Despite this, up to three by fourth of the older adults do not currently exercise at the recommended levels. The relative risk for the cardio-vascular disease caused by sedentary living has been estimated to be low, compared with the other modifiable risk factors such as the hypertension.

Weening-Dijksterhuis E., Scherder EJ., et al (2011) conducted a study on institutionalized frail older patients, a comprehensive review on the physical exercise, physical fitness, the activities of daily living, and the quality of life. Twenty seven trials were included. The sample size ranged from 20 to 981 participants. Four trials have showed strong to very strong effects, five trials have showed moderate or limited effects on the strength and two trials have showed the moderate effects on flexibility, two trials had showed mixed effects on the quality of life and one study showed the mixed effects on coordination. The review concluded that physical training had significantly positive effects on the physical fitness outcomes in the frail older people in long-term care institutions.

Wen-Jui Han., et al (2013) conducted a study on Trajectory of physical health, cognitive function, and psychological well-being among Chinese elderly. Investigation on the trajectory of various dimensions of health well-being among the Chinese elderly in their late years was done. A growth-curve analysis on a subsample of the elderly from the Chinese Longitudinal Health Longevity Survey (CLHLS) was done. The results indicated that the elderly who had relatively advantaged childhood

socioeconomic status and who had been involved in regular physical and/or leisure activities had significantly healthier well-being than their respective counterparts on all dimensions. In addition, regularly participating in physical and/or leisure activities were found to slow down the deterioration of health well-being. Therefore this study highlights the benefits of being physically and/or leisurely active, and the implication to community social service agencies providing resources to facilitate these benefits for the elderly.

Syed Shuja Qadri., et al (2013) conducted an epidemiological study on the Quality of life among the rural elderly population of the Northern India. A community based cross sectional study design was adopted for studying the health problems of the elderly and their health related Quality of life, using the WHOQOL-BREF questionnaire. A simple random sampling technique was used for the data collection. A total of 660 individual who were aged above 60 years of age were taken up for the study purpose. They concluded that there is a need to highlight the medical and the psycho-social problems that are being faced by the older people in India and plans for bringing about an improvement in their quality of life.

Gaetano Santulli., Michele Ciccarelli., et al (2013) conducted a study that physical activity ameliorates cardiovascular health in the elderly's functional role of the β-adrenergic system. An exquisite feature of elderly subjects, who constitute as the growing proportion of the world, who are have high prevalence of the cardio-vascular disorders, which negatively affects both the quality of life and the life expectancy. It is widely accepted that the physical activity represents one of the foremost interventions which is capable in reducing the health burden of the cardio vascular diseases. In the present review, they examined that the relationship between the physical training and the aging, focusing on the functional role of the β-adrenergic system. The amelioration of β-adrenergic receptors responsiveness was obtained through means of regular physical training that contributes to the clinical improvement in the cardiovascular health reported in the elderly patients.

Mary Mathews N., et al (2013) conducted a study on the nutritional aspect of the physical health-related Quality of life in elderly. The descriptive study was conducted to assess the nutritional aspects of the physical health-related Quality of life among the elderly patients attending the MGM Medical College Hospital. 50

elderly's at the age range between 65–75 years of both the sex groups were selected by non-probability convenient sampling technique. They administered standardized mini nutritional assessment tool. Study highlighted the poor nutritional status of the elderly implicating the nurses to maintain the nutritional aspect of the physical health-related Quality of life so as to ensure healthy and productive ageing. It also raises the awareness among the families and the care professionals to the risk of malnutrition.

Lilian Krist., Fernando Dimeo., et al (2013) conducted a pilot study on how can progressive resistance training, twice in a week improve the mobility, the muscle strength, and the quality of life in elderly nursing home residents with impaired mobility. Nursing home residents who were aged 77 and older with impaired mobility were taken for the study. The eight-week exercise program was consisted of progressive-resistance training two times a week. Mobility was assessed with the baseline data and after 8 weeks. Muscle strength was determined by the eight repetitions at the maximum. A short form 36 health survey was used to assess the quality of life. On conclusion it was told that resistance training twice in a week over a period of 2 months seemed to considerably improve the mobility and muscle strength in the patients aged 77–97 years with impaired mobility.

Mariana Martinez Orlando., et al (2013) conducted a study on the influence on the practice of physical activity on the quality of life, the muscle strength, the balance, and the physical ability in the elderly. Observational cross-sectional study was carried out which involved 74 elderly individuals at the city of Santos which were divided into two groups the practitioners and the non-practitioners of physical activity. The International physical activity questionnaire was used for the classification of the participants. The SF-36 questionnaire was used to assess the quality of life. Dynamometry was used to test the muscle strength. A six-minute walk test was used for the assessment of the physical capacity. It was concluded that the elderly individuals in the city of Santos who practiced physical activity had better quality of life, muscle strength, physical capacity and balance in comparison to those who had not practiced physical activity.

Fei Sun1., Ian J Norman., et al (2013) conducted a study on the physical activity in elderly people, a systemic review were fifty three papers were included. The percentage of elderly peoples meetings recommended physical activity that

ranged from 2.4 – 83 percentages across the study. Older age groups people were less likely than the reference group to be regularly active, and the women were less likely than the men to achieve the regular physical activity, especially in the leisure time physical activity, when measured by both the subjective and objective criteria. The review highlights the needs to study which recruit representative random samples of community based elderly people and employ validated measurements consistently to enable comparison of the physical activity levels over time.

SECTION C: ELDERLY AND PSYCHOLOGICAL HEALTH

Neusa Sica Rocha., Mick J. Power., et al (2012) conducted a cross-cultural evaluation of the WHOQOL-BREF domains in primary care depressed patients using rasch analysis. A cross-sectional, cross-national study was done on 1193 patients having a confirmed diagnosis of depression. The results showed that three of the four WHOQOL-BREF domains (physical, psychological, and environment) conform to the rasch model expectations. The social domain showed relatively poor psychometric properties. On conclusion the rasch analysis demonstrated that, with some modifications, all domains of the WHOQOL-BREF, except for the social domain, provide an interval scale measure of generic subjective QOL in the context of depressed primary care patients in six countries

Mariana Chaves Aveiro., Patricia Driusso., et al (2013) conducted a study on the Effects of a physical therapy program on the quality of life among community dwelling older women, randomized controlled trial. The main objective was to verify the effects of the lower intensity and group based physical therapy program on the quality of life. Seventeen women who completed 12-week training program and 10 women were included in control group answered the WHO Quality of life Questionnaire at the reference point and after 12 weeks. The exercise group performed stretching and balance training and they presented a significant improvement for the psychological domain after 12-weeks of physical therapy program. The control group presented a significant worsening for the overall QoL, the physical and the psychological domains. On conclusion a lower intensity group based physical therapy program may be contributed in order women to maintain quality of life and to improve some psychological aspects among the community dwelling older women.

Ricardo Barcelos-Ferreira., et al (2013) conducted a study on Quality of life and the physical activity which are associated to lower the prevalence of depression in community dwellers. This Study investigates the major depression and the associated factors in older people from the developing countries. A cross sectional study which is of a community-based sample of 1563 elderly clients who were aged 60 years or older participated in the study. Major depression was diagnosed in 60 elderly patients. A higher odds ratio of major depression was associated with the female genders, who were being widowed, and who had previous depressive episode, hypertension, use of psycho-tropic medication, and alcohol use. A lower odds ratio of the depression diagnosis was associated with the physical activity and going to cinemas. On conclusion the study showed a significant association between the depression and the potentially modifiable factors, reinforcing the benefit of probable preventive measures, to spur a healthy lifestyle, leisure activities and the practice of physical exercises, as well as the diagnosis and treatment especially in the primary care.

Romulus Cabral Wanderley Lima., et al (2013) conducted a study on Social factors and the improvement of the quality of life of the older persons. The objective of the study was to identify the social aspects relevant to improve the quality of life of elderly. It was found that the approach focused on the physical / functional and pathological characteristics of the elderly is scarce research on approach in the context of social related quality of life. Thus they concluded that studies are required in order to promote citizenship for greater longevity of alternative and complementary practices for healthy aging, increased rehabilitation projects and a political awareness directed towards improving the quality of life of this population.

Seo S., and Cho M., et al (2013) conducted a study on the Relationships among Satisfaction with Food-Related Life, Depression, Isolation, Social Support, and Overall Satisfaction of Life in Elderly South Koreans. This study attempts to measure the satisfaction with food-related life in the elderly of South Korea, while examining differences in social support, depression, isolation, and life satisfaction based on the level of satisfaction with food-related life. A total of 390 elderly (aged 65 and over) who live in Korea participated in this study. The results showed that the elderly with a higher satisfaction with food-related life had a higher social support and

overall satisfaction with their life. On the other hand, the elderly with a lower satisfaction with food-related life generally reported higher levels of depression and isolation. The results of this study indicate that managing the satisfaction with food-related life is an important component of mental health in the elderly.

SECTION D: ELDERLY AND SOCIAL RELATIONSHIP

Kristofer Arestedt., Peter Johansson., et al (2012) conducted a study on the social support and its association with the health related quality of life among elderly patients with chronic heart failure. The main aim of the study is to describe the social support in elderly patients with chronic heart failure in relation to the gender. The Data were collected in 349 elderly patients with heart failure. The interview schedule for social interaction measured the social support. The results showed that social support was rated high, though being a man and living alone, and perceiving a problematic financial situation and high disease severity were associated with lower levels of social support. It was generally associated with health related Quality of life, in particular with the emotional dimensions. On conclusion it was said that taking the social support into an account when caring for older patients with heart failure can be of importance for educating and maintaining the health related quality of life.

Marek Bryłal., Monika Burzyńsk., et al (2013) conducted a study on self - rated Quality of life in city dwelling older people who are benefitting from the social help. The main aim of the study was to identify the factors correlating with the self - rated quality of life of the older people's inhabitants of the cities who applied for social help, on the basis of the cross-sectional study. Four hundred and sixty six samples aged 65 or older were included. An interview questionnaire tool was used for the study. The subjects answered the questions on their demographics, their living conditions, financial status, health and social situation. They also applied the WHO QOL-BREF questionnaire, the geriatric depression scale and the activities of daily living scale. On conclusion the evaluation for the quality of life of the elderly persons depends on many factors and identification of these factors might be helpful in implementing the steps aimed at improving the quality of life of the older people, will need less social help particularly the nursing services.

Rathi Ramachandran., Radhika. R., et al (2013) conducted a sudy on health status of elderly: evidence from India and Japan. This study examined the incidence

of chronic morbidities and functional health of the elderly in India and Japan. The areas for the study were selected using multi stage random sampling technique. From both countries, 50 respondents were identified from each ward using random sampling technique from the voter's list of respective wards. Therefore, the sample consisted of 600 elderly aged 60 years and above, i.e., 300 from each country. Findings of the study indicated the better health status of Japanese elderly compared to India in terms of incidence of chronic morbidities and functional health. Educational and other intervention programmes enhancing physical exercise habits should be imple-mented at community level to reach a large number of elderly. Such preventive health care initiatives by the government could have far reaching effects in mitigating the health related issues of elderly.

Nurizan Yahaya., Yadollah Abolfathi Momtaz., et al (2013) conducted a study on social support and the psychological well-being among the older Malay women's in the peninsular Malaysia. The study investigated the effects of social support on psychological well-being, a random sample of 716 older Malay women were from a national survey. Findings from multiple regression analysis revealed a significant model where psychological well-being was best predicted by non-family support and family support, after controlling for socio demographic factors. Results of this study imply that social support especially from non-family source is a significant predictor of psychological well-being among older women.

SECTION E: ELDERLY AND ENVIRONMENTAL HEALTH

Mohammad Ali Heidarnia., Tahmineh Ghaemian., et al (2013) wrote an article on evaluation of the relation between poverty and health-related quality of life in the people over 60 years-old in the district 4 of Tehran municipality in 2009-2010. This study was designed to evaluate the impact of poverty on QOL. A total of 400 individuals were studied. The results showed significant differences between the two groups in the QOL measures of SF-36, except for physical and mental health measures. The findings indicated that poverty diminishes the QOL in most aspects; however, considering all aspects of QOL is necessary to promote the individuals' health.

V. R. Hariprasad., P. T. Sivakumar., et al (2013) conducted a study on the effects of yoga intervention therapy on sleep and quality of life in the elderly. With a

randomized controlled trial, a total of about 120 patients from nine elderly homes were randomized into yoga group and the wait-list group. Subjects in the yoga therapy group were given yoga intervention therapy daily for a period of over one month and weekly until three months and were encouraged to practice yoga therapy without the supervision until 6 months. Subjects in wait-list group received no interventions. The results showed that the subjects in the yoga therapy group had a significantly higher number of years of formal education, they had a significant improvement in all the domains of the quality of life and the total sleep quality after controlling for the effect of baseline difference in education between the two groups. It was concluded that yoga intervention therapy appears to improve the QOL and sleep quality of elderly living in old age homes.

Kate E. Small., (2013) conducted a study on successful aging and the social contexts: The importance of support, marital status, and spousal influences. The current study examined how different factors align with Rowe and Kahn's (1997) model of the successful aging and their influence on 25-year survival. Participants for this study included 278 community-dwelling older adults from a rural Midwestern county. The results showed that overall, having better physical functioning, low chronic illness, and higher ratings of perceived social support significantly predicted survival over 25 years. Depressive symptoms, church attendance, and participating in volunteer activities were unrelated to survival. The implications from this research are to promote the maintenance of social relationships throughout adulthood and to focus on social interventions for at-risk individuals, such as those reporting low levels of perceived support.

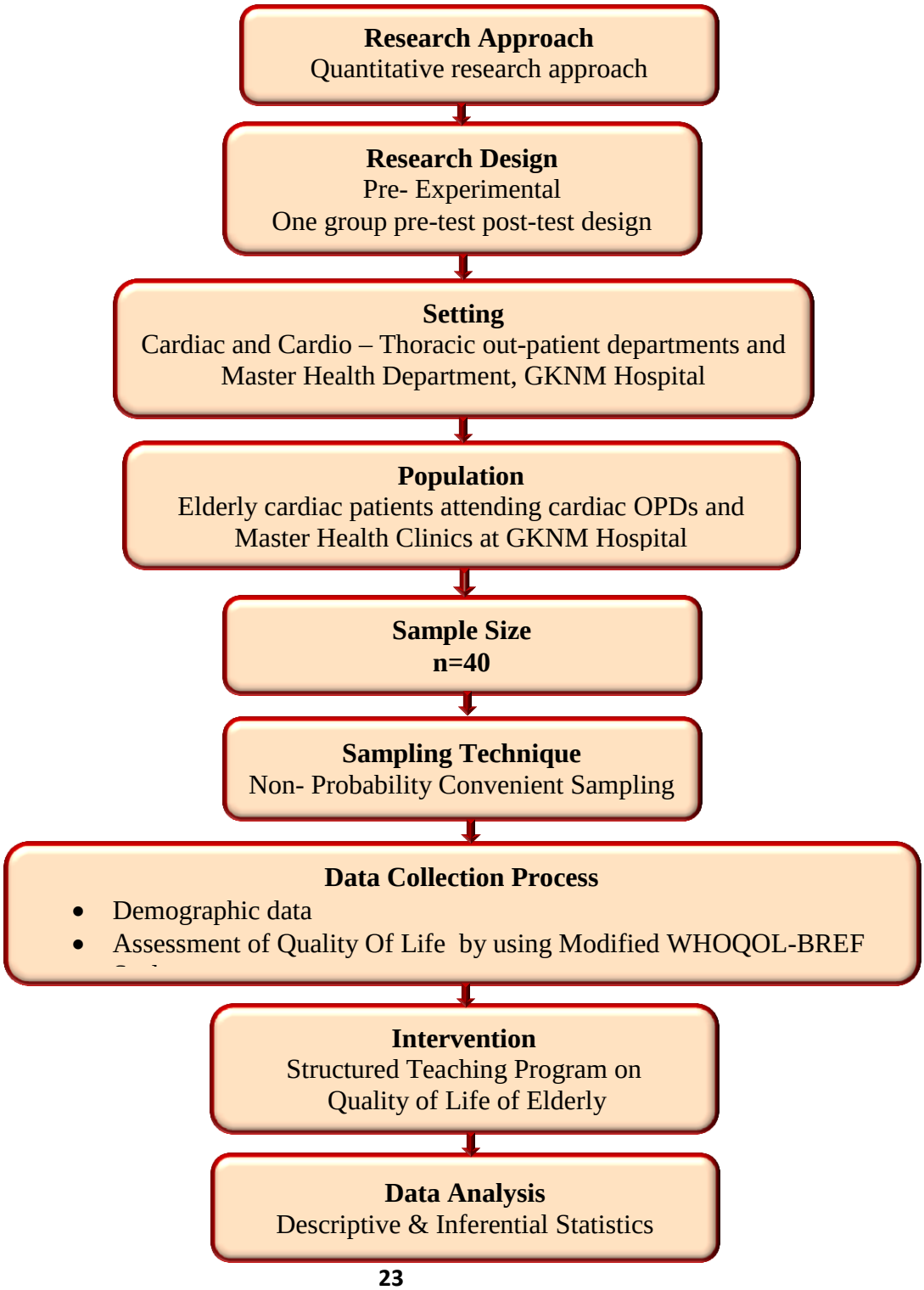
Abdul Rashid., Azizah Ab Manan., et al (2013) conducted a study on The Quality of life of Elderly Living in a Home for the aged in Penang Malaysia. A cross sectional study was conducted in an old folk's home in Penang, Malaysia. The quality of life of the respondents was measured using WHOQOL-BREF. The results showed that the mean WHOQOL-BREF score and the mean scores of all the four domains were above average suggesting a trend towards a higher quality of life. The social relations domain had the lowest scores among all the domains. On conclusion it is said that poor social relationship is an important associated factor for poor quality of life

CHAPTER – III

METHODOLOGY

Research methodology is the systematic way to solve the research problem. Methodology is one which enables the researcher to project a blue print of the research undertaken.

FIGURE: 3.1 – SCHEMATIC REPRESENTATION OF RESEARCH METHODOLOGY



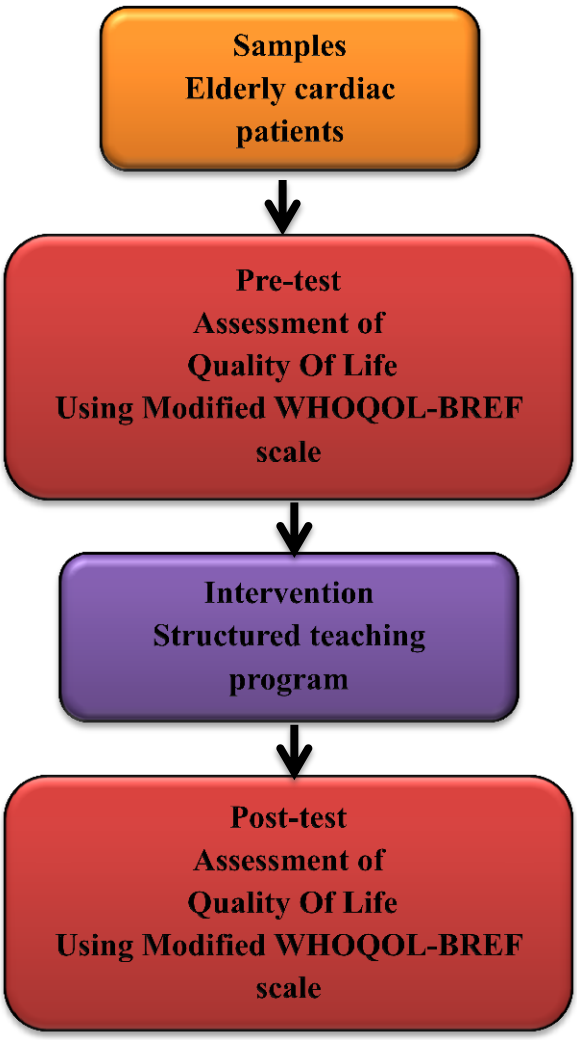
RESEARCH APPROACH

Quantitative research approach was selected to assess the effectiveness of structured teaching program on quality of life among elderly cardiac patients.

RESEARCH DESIGN

The research design provides an overall plan for conducting the study. The research design adopted for this study is Pre- Experimental, One group Pre- test Post-test Design. In this present study a pre-test was administered by means of self-administered questionnaire and then, implementation of structured teaching program was given, post- test was carried out on the next consequent visit with the same questionnaire.

FIGURE: 3.2 – SCHEMATIC REPRESENTATION OF RESEARCH DESIGN



VARIABLES

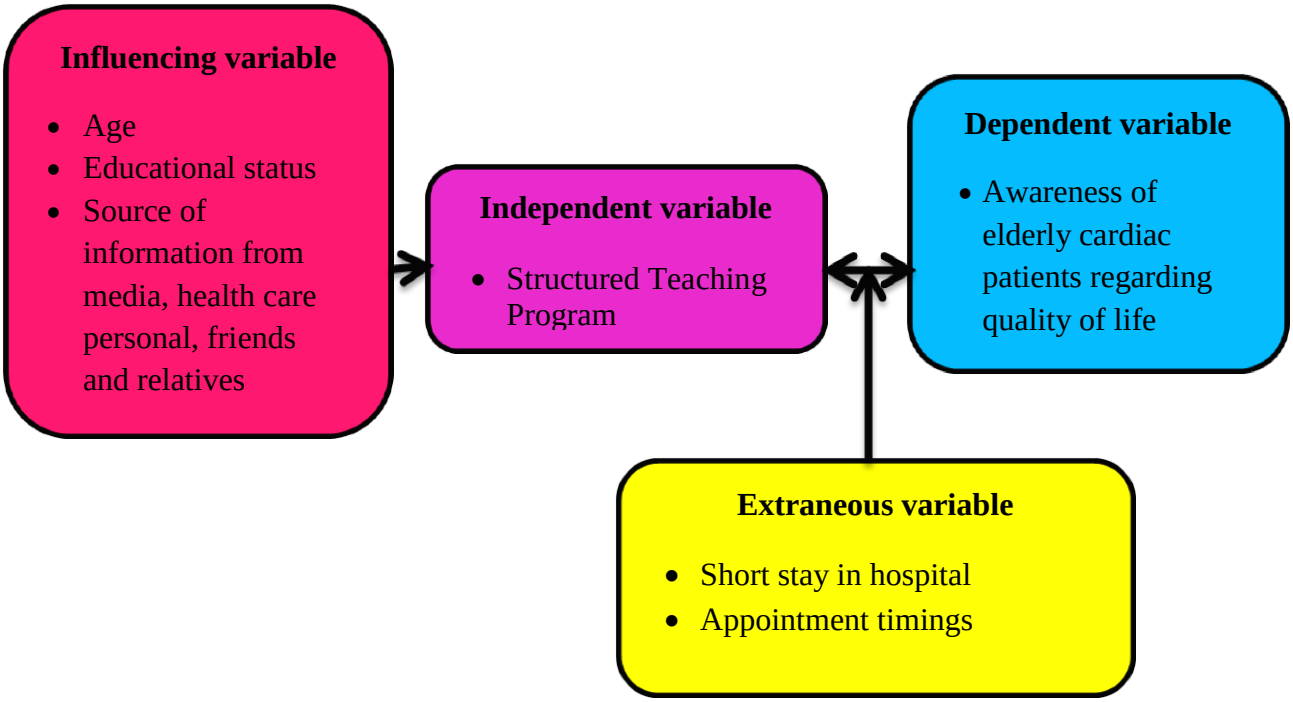
Influencing variable: Age, Educational status, Source of information from media, health care personal, friends and relatives.

Independent variable: Structured Teaching Program on Awareness of Quality Of Life.

Dependent variable: Awareness of elderly cardiac patients regarding quality of life

Extraneous variable: Short stay in hospital and appointment timings

FIGURE: 3.3 - SCHEMATIC REPRESENTATION OF VARIABLES



SETTING OF THE STUDY

The study was conducted at cardiology and cardio-thoracic out-patient departments and master health department of G.Kuppuswamy Naidu Memorial Hospital, Coimbatore, which is a super-specialty tertiary care center.

POPULATION

The population of the study was comprised of elderly cardiac patients who are attending cardiac OPDs and Master Health Clinics at GKNM Hospital.

SAMPLE SIZE

The sample size was determined by using Mahajan's Formula

Sample size (n) = $\frac{4Pq}{L^2}$

P = (120 /1440) x 100 = 8.33

q = 100 – 8.33 = 91.6

P = Percentage of population

L = 9

q = 100-P

$n = \frac{4Pq}{L^2} = (4 \times 91.6 \times 8.33)/ 81 = 37.68$

L = Allowable error

According to this, it was decided to have 40 samples for this study

SAMPLING TECHNIQUE

Non Probability Convenient Sampling technique was adopted for the study.

SAMPLING CRITERIA

Inclusion criteria:

- Patients who are willing to participate in the study
- Patients who can read and write Tamil or English.

Exclusion criteria:

- Patients who are not on regular OPD basis
- Patients who have visual and auditory impairment

DESCRIPTION OF THE TOOL

The tool consists of 2 sections, such as section A & B

Section A - Demographic Data

It consist of the demographic variables of the subjects which included age, sex, education, occupation, religion, marital status, family type, monthly income, present illness, activities of daily living, self-esteem and family relationship

Section B - Modified WHOQOL Rating Scale

It is a 26-item instrument consisting of four domains, the physical health (7 items), the psychological health (6 items), social relationships (3 items), and environmental health (8 items), it also contains QOL and general health items. Each individual item of the WHOQOL-BREF is scored from 1 to 5 on a response scale, which is stipulated as a five-point ordinal scale. The scores are then transformed linearly to a 0–100-scale and the scoring criteria, it ranges from poor (25-50), good (51-75), very good (76-100)

DESCRIPTION OF INTERVENTION

The elderly cardiac patient's quality of life was assessed using modified WHOQOL-BREF rating scale and structured teaching program was given and post-test was done on the next consequent visit by using the same questionnaire.

FIGURE: 3.4 - SCHEMATIC REPRESENTATION OF INTERVENTION

VALIDITY

The tool and the teaching module were submitted for validation to experts in the field of Geriatric Medicine in G. Kuppuswamy Naidu Memorial Hospital and Department of Medical Surgical Nursing in GKNM Institute of Nursing and Nursing experts from other Nursing Colleges in and around Coimbatore. The translated Tamil version was validated by Tamil experts. Based on the suggestions and recommendations, the tool and the module were modified for the main study.

RELIABILITY

The reliability of the tool was determined by Spearman Brown's Split half technique.

"r" value was found reliable (r = 0.83).

Reliability was computed by the following equation:

$$r = \frac{\Sigma (X - \bar{X})(Y - \bar{Y})}{\sqrt{\Sigma (X - \bar{X})^2 \times \Sigma (Y - \bar{Y})^2}}$$

ETHICAL CONSENT

The consent to conduct the study was obtained from the ethical committee of G. Kuppuswamy Naidu Memorial Hospital, Coimbatore.

PILOT STUDY

The pilot study was conducted in the Cardiac and Cardio-Thoracic Out-Patient departments and master health department of G. Kuppuswamy Naidu Memorial Hospital, Coimbatore, for a period of 2 weeks from 15.07.2013 to 26.07.13. A total of 10 samples were selected for the study using non-probability convenient sampling technique. Informed consent was obtained and demographic data were collected from the participants. Self-administered questionnaire was used to assess the Quality Of Life and a structured teaching program was provided to the participants. The result showed that, the structured teaching program was effective in improving their awareness on Quality Of Life. Upon completion of pilot study, the feasibility &

practicability of the tool was assessed. The necessary changes were made to the tool based on the pilot study results.

DATA COLLECTION PROCEDURE

The data collection period was for four weeks. Data were collected every day from 29. 07. 2013 to 24. 08. 2013. The samples selected were given self-introduction and oral consent was obtained. The participants were assured about the confidentiality of the data collected and that it will be used only for research purpose. The pre-test level of Quality of Life was assessed, on the out-patient basis using WHOQOL – BREF scale followed by which structured teaching program was implemented. It was followed by an interactive session for the patient as well as the family members to clarify their queries and to furnish with adequate explanations. Post- test level of Quality Of Life was assessed in the consequent visit by using the WHOQOL – BREF scale.

PLAN FOR DATA ANALYSIS

- The data collected from subjects were compiled and analyzed using descriptive statistics such as frequency, mean, percentage and standard deviation.
- To test the effectiveness of the structured teaching program, paired ‘t’ test was used.
- The association between pre-test level of scores and selected demographic variables of the subjects were tested using Chi square test.

CHAPTER-IV

ANALYSIS AND INTERPRETATION

Analysis is defined as the process of systematically applying statistical and logical techniques to describe, summarize and compare data.

-Suresh K. Sharma (2011)

This chapter deals with the analysis and interpretation of data collected from 40 elderly cardiac patients, to assess the effectiveness of structured teaching program on the awareness of quality of life among elderly cardiac patients. The findings are based on descriptive and inferential statistical findings are tabulated and described below:-

Table 4.1: Distribution of demographic variables of elderly cardiac patients

Table 4.2: Distribution of level of awareness on physical, psychological, social, environmental domains in quality of life

Table 4.3: Comparison of pre-test and post-test scores on awareness of quality of life

Table 4.4: Association of selected demographic variables with the pre-test scores of physical domain

Table 4.5: Association of selected demographic variables with the pre-test scores of psychological domain

Table 4.6: Association of selected demographic variables with the pre-test scores of social domain

Table 4.7: Association of selected demographic variables with the pre-test scores of environmental domain

TABLE - 4.1

DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF ELDERLY CARDIAC PATIENTS

n=40

SI. No	Demographic Variable	Frequency (f)	Percentage (%)
1	**Age in Years**		
	a) 60 – 69	20	50
	b) 70 – 79	17	42.5
	c) 80 and above	3	7.5
2	**Sex**		
	a) Male	25	62.5
	b) Female	15	37.5
3	**Education**		
	a) Illiterate	14	35
	b) School Level	25	62.5
	c) Undergraduate	0	0
	d) Postgraduate	1	2.5
4	**Occupation**		
	a) Unemployed	13	32.5
	b) Self-employed	23	57.5
	c) Private employee	3	7.5
	d) Retired	1	2.5
5	**Religion**		
	a) Hindu	29	72.5
	b) Muslim	5	12.5
	c) Christian	6	15
	d) Others	0	0
6	**Marital Status**		
	a) Married	26	65
	b) Single	0	0
	c) Widowed	14	35
7	**Type of Family**		
	a) Nuclear	20	50
	b) Joint	20	50
8	**Monthly Income**		
	a) Rs. 10,001 – 20,000	15	37.5
	b) Rs. 20,001 – 30,000	21	52.5
	c) Above Rs. 30,000	4	10
9	**Present Illness**		
	a) Hereditary	0	0
	b) Systemic	40	100

10	**Activities Of Daily Living**		
	a) Independent	27	67.5
	b) Need some help	12	30
	c) Completely dependent	1	2.5
11	**Self-Esteem**		
	a) Self – Respect	40	100
	b) Underestimate yourself	0	0
	c) Inferiority complex	0	0
12	**Family Relationship**		
	a) Low level	29	72.5
	b) Moderate level	9	22.5
	c) High level	2	5

Table (4.1) shows the distribution of demographic variables.

Age: It reveals that 20(50%) patients were in the age group of 60-69 years, 17(42.5%) patients were in the age group of 70-79 years, and 3(7.5%) patients were in the age group above 80 years.

Sex: It denotes that 25(62.5%) patients belongs to male gender and 15(37.5%) patients were in female gender.

Education: The educational status is that 14(35%) were illiterate and 25(62.5%) were school level of education.

Occupation status: The occupational status reveals that 13(32.5%) were unemployed and 23(57.5%) were self-employed.

Religion: In the religion 29(72.5%) belonged to Hindu religion, 5(12.5%) belonged to Muslim religion and 6(15%) were belonged to Christianity

Marital Status: The marital status reveals that 26(65%) were married and 14(35%) were widowed.

Type of family: In the type of family 20(50%) belonged to nuclear family and 20(50%) were in joint family.

Monthly Income: The monthly income was that 21(52.5%) had an income between Rs. 20,001- 30,000.

Activities of Daily Living: The activities of daily living was that 27(67.5%) were independent and 12 (30%) needs some help.

Family Relationship: The family relationship shows that 29(72.5%) belonged to low level and 9(22.5%) belonged to moderate level.

FIGURE: 4.1 DISTRIBUTIONS OF ELDERLY CARDIAC PATIENTS WITH AGE

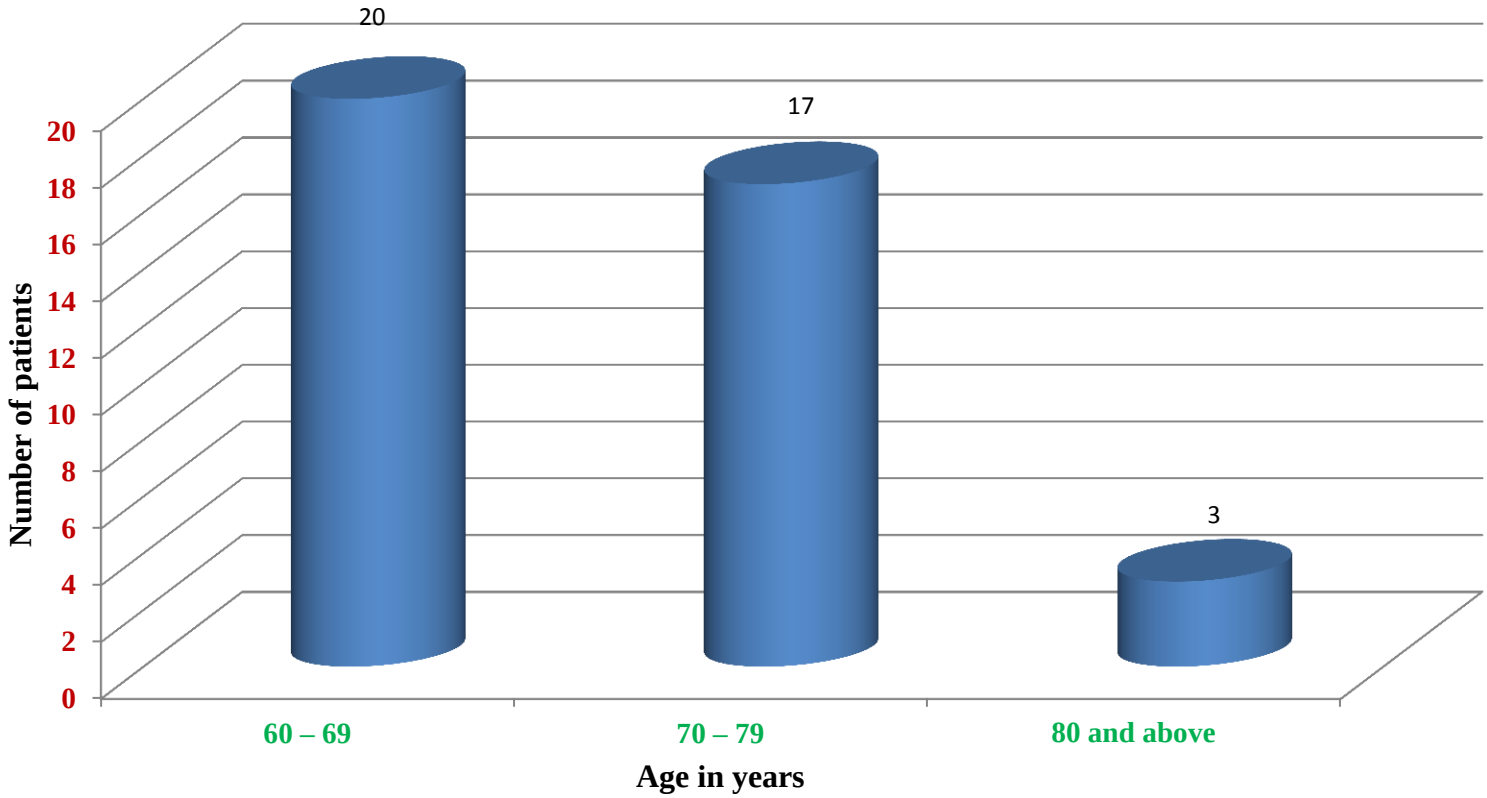


FIGURE: 4.2 DISTRIBUTIONS OF ELDERLY CARDIAC PATIENTS WITH SEX

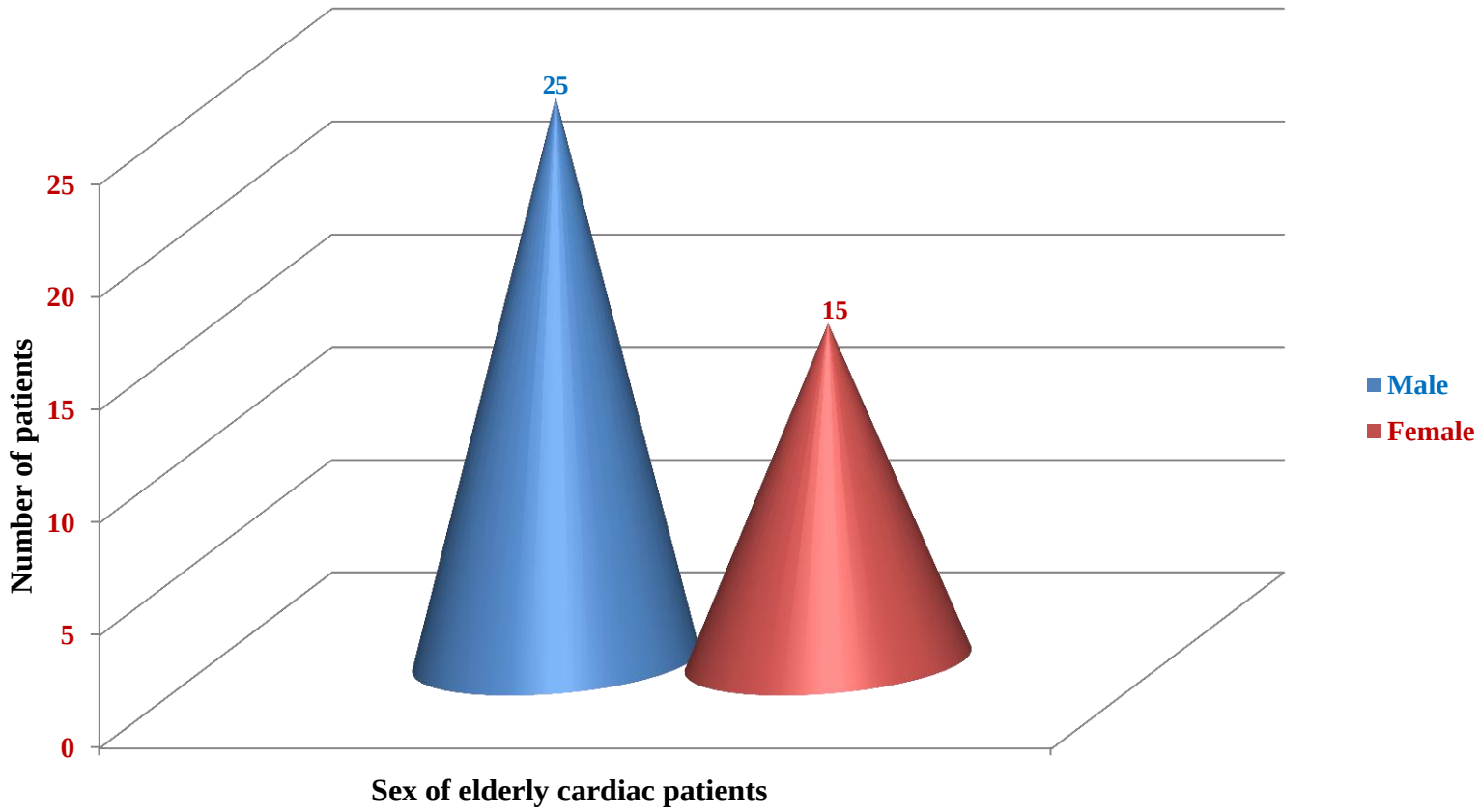


TABLE 4.2

DISTRIBUTION ON LEVEL OF AWARENESS ON PHYSICAL, PSYCHOLOGICAL, SOCIAL, ENVIRONMENTAL DOMAINS OF QUALITY OF LIFE

n=40

Quality of life		**Domain**	**Pre-test**		**Post-test**	
Category	**Scores**		**f**	**%**	**f**	**%**
Poor	25 – 50	**Physical**	36	90	1	2.5
Good	51 – 75		4	10	20	50
Very Good	76 – 100		0	0	19	47.5
Poor	25 – 50	**Psychological**	34	85	0	0
Good	51 – 75		5	12.5	23	57.5
Very Good	76 – 100		1	2.5	17	42.5
Poor	25 – 50	**Social**	33	82.5	4	10
Good	51 – 75		4	10	17	42.5
Very Good	76 – 100		3	7.5	19	47.5
Poor	25 – 50	**Environment**	34	85	2	5
Good	51 – 75		5	12.5	21	52.5
Very Good	76 – 100		1	2.5	17	42.5

Table (4.2) shows the level of awareness of physical, psychological, social, environmental domains of quality of life.

- In physical domain the level of scores on awareness of quality of life in pre-test is that 36(90%) had poor awareness, 4(10%) had good awareness and none had very good awareness and in post-test 1(2.5%) had poor awareness, 20(50%) had good awareness and 19(47.5%) had very good awareness.

- In psychological domain the level of scores on awareness of quality of life in pre-test is that 34(85%) had poor awareness, 5(12.5%) had good awareness and 1(2.5%) had very good awareness and in post-test 23(57.5%) had good awareness and 17(42.5%) had very good awareness.

- In social domain the level of scores on awareness of quality of life in pre-test is that 33(82.5%) had poor awareness, 4(10%) had good awareness, 3(7.5%) had very good awareness and in post-test 4(10%) had poor awareness, 17(42.5%) had good awareness, 19(47.5%) had very good awareness.

- In environmental domain the level of scores on awareness of quality of life in pre-test is that 34(85%) had poor awareness, 5(12.5%) had good awareness, and 1(2.5%) had very good awareness in post-test 2(5%) had poor awareness, 21(52.5%) had good awareness, and 17(42.5%) had very good awareness.

FIGURE-4.3 DISTRIBUTION OF LEVEL OF AWARENESS ON PHYSICAL DOMAIN

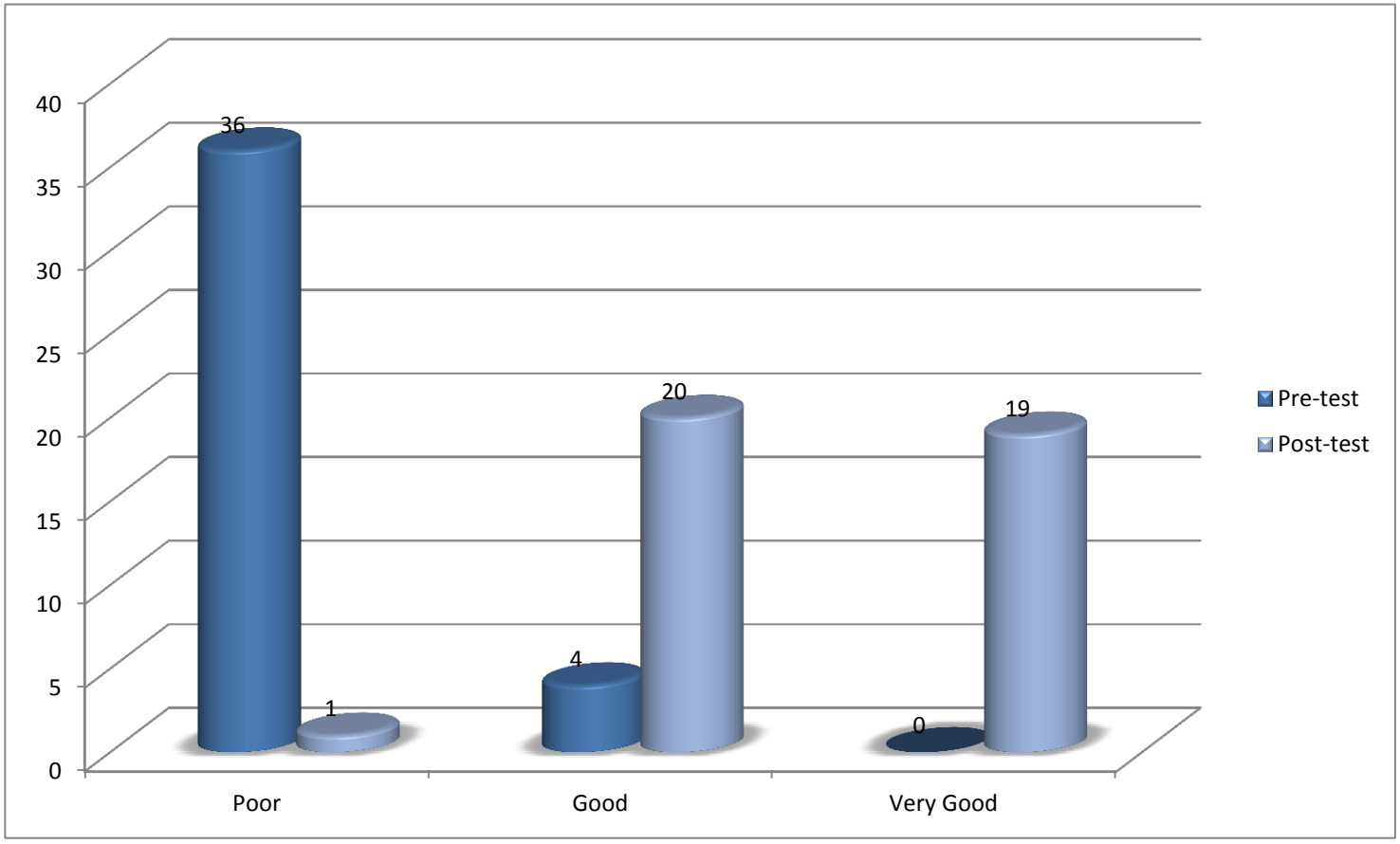


FIGURE-4.4 DISTRIBUTION OF LEVEL OF AWARENESS ON PSYCHOLOGICAL DOMAIN

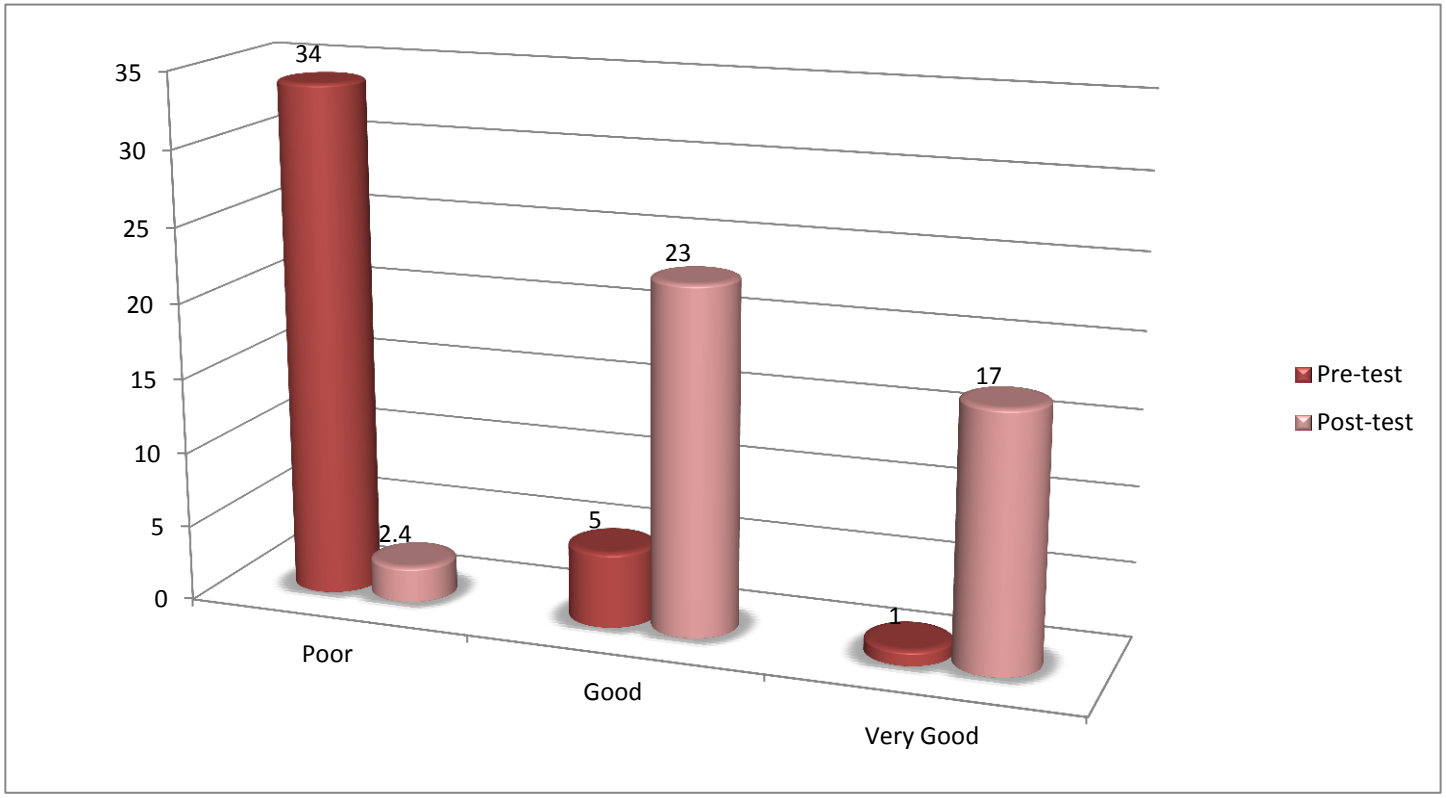


FIGURE-4.5 DISTRIBUTION OF LEVEL OF AWARENESS ON SOCIAL DOMAIN

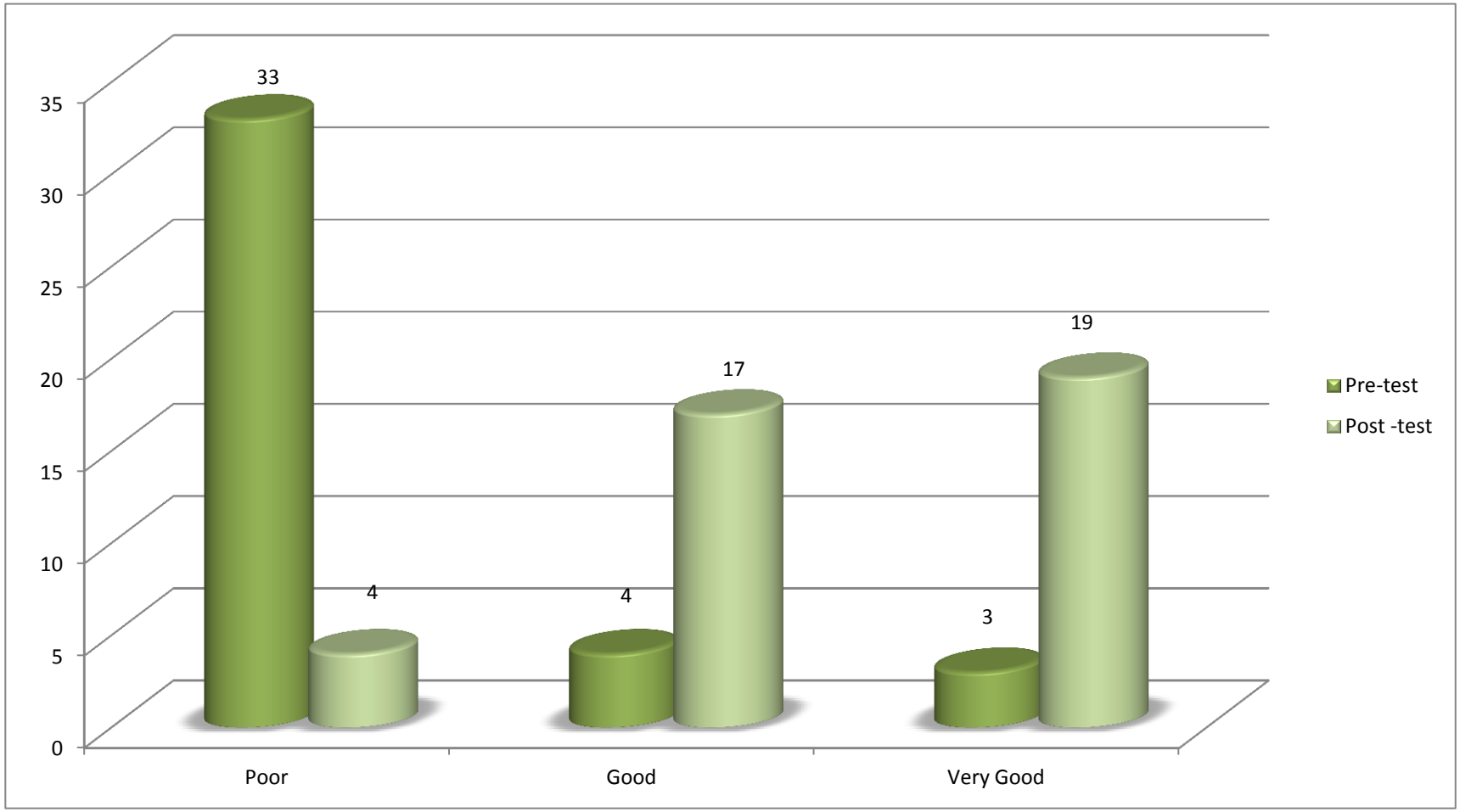


FIGURE: 4.6 DISTRIBUTION OF LEVEL OF AWARENESS ON ENVIRONMENTAL DOMAIN

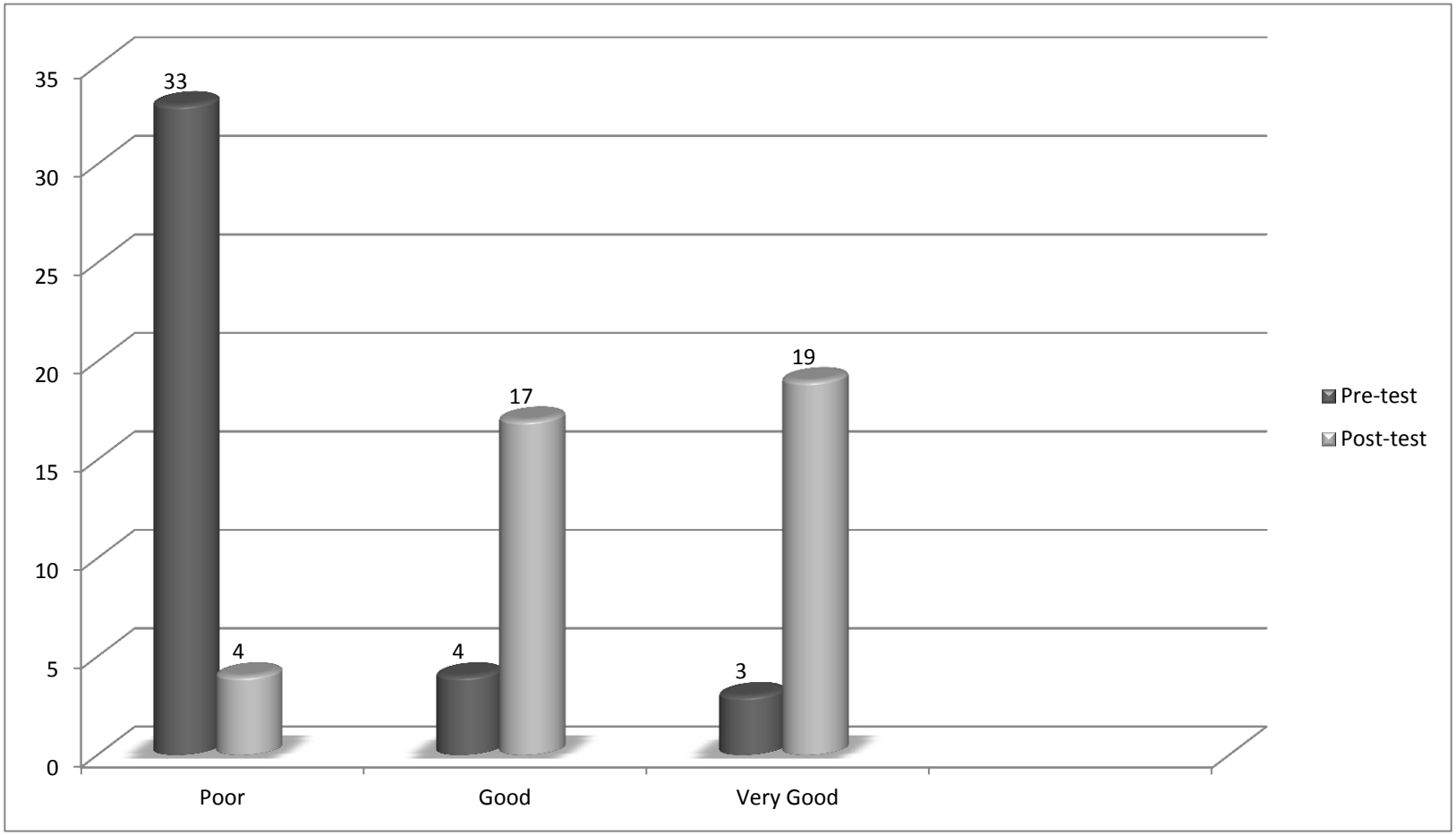


TABLE 4.3

COMPARISON OF PRE-TEST AND POST-TEST SCORES ON AWARENESS OF QUALITY OF LIFE

n=40

Quality of life	Pre-test		Post-test		Mean difference	Paired 't' test
	Mean	SD	Mean	SD		
Physical Domain (7-35)	17.5	3.71	28.15	2.9	10.65	13.01*
Psychological Domain (6-30)	15.3	3.61	23.75	2.2	8.45	12.29*
Social Domain (3-15)	7.4	2.7	11.9	2	4.53	10.68*
Environmental Domain (8-40)	21.85	3.6	31.20	3.4	9.35	11.10*
Overall Perception of Quality of Life (2-10)	5.13	2.01	8.3	0.87	3.18	11.01*
Overall (26-130)	67.15	8.8	103.3	4.7	36.15	23.29*

*Significant at P<0.05 level at df 39, t- value 2.021

Table (4.3) shows the comparison of pre-test and post-test scores on awareness of Quality of Life. In physical domain the't' value was 13.01, with regard to psychological domain the't' value was 12.29, regarding the social domain the't' value was 10.68, in the environmental domain the't' value was 11.10, concerning the overall perception of quality of life the 't' value was 11.01, and regarding the overall quality of life the 't' value was 23.29.

The above table says that the calculated't' value is higher than the table value (2.021). Therefore there is a significant difference in pre-test and post-test scores on the awareness of quality of life

TABLE - 4.4

ASSOCIATION OF SELECTED DEMOGRAPHIC VARIABLES WITH THE PRE-TEST SCORES OF PHYSICAL DOMAIN

SI. No	Demographic Variables	Quality of Life			Chi squire value	Table value (5%)	Significance
		Poor	Good	Very Good			
	Age in years				χ^2= 4.26 df=2	5.99	NS
1	60 – 69	17	3	--			
2	70 – 79	17	0	--			
3	80 and above	2	1	--			
	Sex				χ^2= 2.7 df= 1	3.841	NS
1	Male	21	4	--			
2	Female	15	0	--			
	Education				χ^2= 9.2 df= 2	5.99	S
1	Illiterate	13	1	--			
2	School Level	23	2	--			
4	Postgraduate	0	1	--			
	Activities Of Daily Living				χ^2= 0.19 df= 2	5.99	NS
1	Independent	24	3	--			
2	Need some help	11	1	--			
3	Completely dependent	1	0	--			

This table (4.4) shows association of demographic data with the level of awareness of quality of life of physical domain.

- The above table shows that the calculated value of education, χ=9.2 at df=2 was significant at 0.05 level. Therefore it has an association with education and awareness on quality of life.
- The demographic variables such as age, sex, activities of daily living were not significant at 0.05 level so it has no association with the level of awareness oN quality of life

TABLE- 4.5

ASSOCIATION OF SELECTED DEMOGRAPHIC VARIABLES WITH THE PRE-TEST SCORES OF PSYCHOLOGICAL DOMAIN

SI. No	Demographic variables	Quality of Life			Chi squire value	Table value	Level of significance
		Poor	Good	Very Good			
	Age in years				χ^2= 3.35 df= 4	9.48	NS
1	60 - 69	15	4	1			
2	70 - 79	16	1	0			
3	80 and above	3	0	0			
	Sex				χ^2= 1.45 df= 2	5.99	NS
1	Male	20	4	1			
2	Female	14	1	0			
	Occupation				χ^2= 5.23 df= 6	12.59	NS
1	Unemployed	13	0	0			
2	Self-employed	17	5	1			
3	Private employee	3	0	0			
4	Retired	1	0	0			
	Activities Of Daily Living				χ^2= 0.85 df= 4	9.48	NS
1	Independent	23	3	1			
2	Need some help	10	2	0			
3	Completely dependent	1	0	0			

This table (4.5) shows association of demographic data with the level of awareness of quality of life of psychological domain.

- The demographic variables such as age, sex, occupation, and activities of daily living were not significant at 0.05 level so it has no association with the level of awareness of quality of life.

TABLE-4.6

ASSOCIATION OF SELECTED DEMOGRAPHIC VARIABLES WITH THE PRE-TEST SCORES ON SOCIAL DOMAIN

S. no	Demographic variables	Quality of Life			Chi squire value	Table value	Level of significance
		Poor	Good	Very Good			
	Education				χ^2=2.3 df=4	9.48	NS
1	Illiterate	12	2	0			
2	School Level	20	2	3			
3	Postgraduate	1	0	0			
	Occupation				χ^2=3.8 df=6	12.5	NS
1	Unemployed	12	0	1			
2	Self-employed	17	4	2			
3	Private employee	3	0	0			
4	Retired	1	0	0			
	Religion				χ^2=2.13 df=4	9.48	NS
1	Hindu	23	3	3			
2	Muslim	5	0	0			
3	Christian	5	1	0			
	Marital Status				χ^2=4.47 df=2	5.99	NS
1	Married	22	1	3			
2	Widowed	11	3	0			
	Monthly Income				χ^2=5.1 df=4	9.488	NS
1	Rs. 10,001 – 20,000	13	0	2			
2	Rs. 20,001 – 30,000	16	4	1			
3	Above Rs. 30,000	4	0	0			

This table (4.6) shows association of demographic data with the level of awareness of quality of life of psychological domain.

- The demographic variables such as education, occupation, religion, marital status, and monthly income were not significant at 0.05 level so it has no association with the level of awareness of quality of life.

TABLE- 4.7

ASSOCIATION OF SELECTED DEMOGRAPHIC VARIABLESWITH THE PRE-TEST SCORES OF ENVIRONMENTAL DOMAIN

S. no	Demographic variables	Level of pain			Chi squire value	Table value	Level of significance
		Poor	Good	Very Good			
	Type of Family				χ^2=1.21 df=2	5.99	NS
1	Nuclear	16	3	0			
2	Joint	17	2	1			
	Family Relationship				χ^2=1.5 df=4	9.48	NS
1	Low level	25	3	1			
2	Moderate level	7	2	0			
3	High level	2	0	0			
	Monthly Income				χ^2= 6.39 df= 4	9.48	NS
1	Rs. 10,001 – 20,000	15	0	0			
2	Rs. 20,001 – 30,000	15	5	1			
3	Above Rs. 30,000	4	0	0			
	Marital Status				χ^2= 2.35 df=2	5.99	NS
1	Married	22	4	0			
3	Widowed	12	1	1			

This table (4.7) shows association of demographic data with the level of awareness of quality of life of psychological domain.

- The demographic variables such as type of family, family relationship, monthly income and marital status were not significant at 0.05 level so it has no association with the level of awareness of quality of life.

CHAPTER - V

RESULTS AND DISCUSSION

The present study has been undertaken to identify the effectiveness of structured teaching program on awareness of quality of life of elderly cardiac patients.

The collected data for the present study was analyzed statistically and the results based on the objectives are discussed below:

1. **To assess the quality of life of elderly cardiac patients**

Table 4.2 showed that the level of awareness of quality of life of physical, psychological, social, environmental domain in quality of life.

- The level of awareness of physical domain in quality of life is that 36(90%) had poor awareness, 4(10%) had good awareness and none had very good awareness.
- The level of awareness of psychological domain in quality of life is that 34(85%) had poor awareness, 5(12.5%) had good awareness and 1(2.5%) had very good awareness in psychological domain.
- The level of awareness of social domain in quality of life is that 33(82.5%) had poor awareness, 4(10%) had good awareness, 3(7.5%) had very good awareness.
- The level of awareness of environmental domain in quality of life is that 34(85%) had poor awareness, 5(12.5%) had good awareness, and 1(2.5%) had very good awareness.

Syed Shuja Qadri., et al (2013) conducted an epidemiological study on quality of life among the rural elderly populations of northern India. A cross-sectional design was adopted to study the health problems and their health related quality of life. 660 individuals who were above 60 years of age were taken for the study. A majority of about 68.2% of elderly have a good quality of life, while those who have a fair/poor quality of life were below 15%. The Quality of life was better in males in physical, psychological, social and environmental domains. As a result, there is a need to highlight the medical and psycho-social problems that are being faced by the

elderly people, and indeed, plans should be brought out for the improvement in their quality of life.

The findings of the study are in agreement with the above cited reviews which emphasizes that it is essential for the elderly to have awareness on quality of life.

2. **To assess the effectiveness of structured teaching program**

Table (4.3) showed the comparison of pre-test and post-test scores on awareness of Quality of Life. In physical domain the 't' value was 13.01, with regard to psychological domain the 't' value was 12.29, regarding the social domain the 't' value was 10.68, in the environmental domain the 't' value was 11.10, concerning the overall perception of quality of life the 't' value was 11.01, and regarding the overall quality of life the 't' value was 23.29 and the calculated 't' value is higher than the table value (2.021) with the degrees of freedom 39. Therefore there is a significant difference in pre-test and post-test scores on the awareness of quality of life.

Frode Gallefoss., Per Sigvald Bakke., et al (1999) conducted a randomized controlled study on the Quality of Life Assessment after Patient Education on Asthma and Chronic Obstructive Pulmonary Disease. They randomly allocated 78 patients with asthma and 62 COPD patients to either a control or an experimental group. The results showed that the asthmatics showed enhanced health related Quality of life and good lung function after patient education to those compared with the asthmatics who were not educated.

Salvador García., (2011) had done a project on improving seniors' quality of life: a toolkit to evaluate education for elderly learners. The aim was to increase the skills of the staffs, the specialists and the teachers working in "education for senior citizens" and by providing a useful guide and practical concepts together, with an evaluation toolkit, based on the quality indicators that provide the recommendations. The outcome of the project was to design a practical evaluation toolkit to assess an educational process by identifying the areas of improvement, and making recommendations. The toolkit had 38 quality indicators in 7 educational dimensions (premises, staff, management, activities, models, courses and pedagogy) and seven Quality of life dimensions (physical and psychological well-being, control, integration

personal fulfillment, participation, and personal growth). Each dimensions were located in all of the previous dimensions in order to offer a scale of requirements, so that an educational intervention is met to increase the impact on the elderly person's Quality of life. These indicators offer assistance to the theoretical concepts and practical experiences.

Sangappa., and Meti., (2013) conducted a quasi-experimental study to assess the effectiveness of the structured-teaching program regarding the knowledge on geriatric care among elderly people in family setting, under selected rural populations at Mangalore. The study findings revealed that there was a deficient knowledge regarding the geriatric care in the family setting. The teaching was found to be effective in improving the knowledge of the elderly. It was concluded that the STP was effective in enhancing the knowledge regarding geriatric care for elderly.

The findings of the study are in agreement with the above cited reviews which emphasized that structured teaching program on awareness of quality of life is effective among elderly cardiac patients.

3. To find the association between the pre- test level of scores and selected demographic variables

Table (4.4) showed association of demographic data with the level of awareness of quality of life of physical domain. It shows that the calculated value of education, χ^2=9.2 was significant at 0.05 level. Therefore it has an association with education and awareness on quality of life. The demographic variables such as age, sex, activities of daily living were not significant at 0.05 levels so it has no association with the level of awareness of quality of life.

Table (4.5) showed association of demographic data with the level of awareness of quality of life of psychological domain. The demographic variables such as age, sex, occupation, and activities of daily living were not significant at 0.05 levels so it has no association with the level of awareness of quality of life.

Table (4.6) showed association of demographic data with the level of awareness of quality of life of social domain. The demographic variables such as education, occupation, religion, marital status, and monthly income were not

significant at 0.05 levels so it has no association with the level of awareness of quality of life.

Table (4.7) showed association of demographic data with the level of awareness of quality of life of environmental domain. The demographic variables such as type of family, family relationship, monthly income and marital status were not significant at 0.05 levels so it has no association with the level of awareness of quality of life

Ewa Szynkiewicz., and Małgorzata Filanowicz., et al (2013) conducted a study on the analysis of the impact on selected demographic aspects on quality of life of asthmatic patients. The results had showed that there was no significant difference between quality of life, and sex and the place of residence of the respondents. It was concluded that age, education, professional activity, marital status and financial situations affect the assessment of quality of life in asthmatic patients. Demographic aspects such as sex and the place of living have no effect in the assessment of quality of life in asthmatic patients.

The findings of the study are in agreement with the above cited reviews emphasize the association between the pre-test level of scores and selected demographic variables.

The findings of the study revealed that the structured teaching program was effective in creating awareness on quality of life among elderly cardiac patients.

CHAPTER - VI

SUMMARY, CONCLUSION, NURSING IMPLICATIONS AND RECOMMENDATIONS

SUMMARY

The researcher felt that there was a need for creating awareness in elderly cardiac patients about the quality of life will help them to learn and involve themselves in maintaining a good health in all aspects like physical, psychological, social and environment.

The researcher selected this study to find the effectiveness of structured teaching program on awareness of quality of life of elderly cardiac patients in GKNM Hospital, Coimbatore.

An extensive review of literature and guidance of experts lead the researcher to lead on with the study. A pre-experimental, one group pre-test, post-test research design was adopted for the study. Pilot study was conducted for 2 weeks to assess the reliability and feasibility of the tool. After pilot study the reliability of the tool was checked by using split-half method and it was found reliable.

Forty samples that had fulfilled the inclusion criteria were selected for the study using non-probability convenient sampling technique. An oral consent was obtained and they were assessed for the quality of life using the WHOQOL-BREF Scale. On the same day the structured teaching was given regarding, exercise, nutrition, sleep, medication safety, alternatives ways to alleviate pain, skin protection, social wellness, cognitive well- being, psychological well- being, emotional health, safety measures and environmental health. Post- test was done on the next consequent visit by using WHOQOL-BREF Scale.

The findings of the study revealed that the structured teaching program was effective in creating awareness on quality of life among elderly cardiac patients.

CONCLUSION

The findings of the study proved the effectiveness of structured teaching program on the awareness of quality of life among elderly cardiac patients.

Considering the study findings, teaching program for elderly patients who are attending the out-patient departments and master health departments can be routinely adopted in the hospital so that it may improve their health and a happy living.

NURSING IMPLICATIONS

Nursing has now bloomed as a profession and we ought to implement our knowledge and experience in all the spheres of the profession such as Nursing service, education, research and administration; which paves the way for better future of Nursing as a profession and Nurses as professionals.

Nursing Practice

- A protocol can be made and nurses should teach the elderly the ways to improve their quality of life and should insist them to practice on a regular basis and to follow them up every month.
- Health education programs can be conducted by the nursing personal in the hospital and community settings for the elderly to increase their knowledge on awareness on quality of life on various aspects for a better health. Several educational strategies can be used to disseminate the health education like printed materials, posters, booklets.

Nursing Education

- The student nurses must realize that imparting heath information for the elderly is a major concern and should be assessed periodically for improving their quality of life.
- The nurse educator should arrange in-service education program regularly for the student nurses for updating their knowledge on the aspect of elderly quality of life.
- The curriculum should include the various aspects of geriatric care and the needs of geriatric patients.

Nursing Administration

- Nurse administrators should encourage the nurses to educate the elderly regarding regular physical activity, nutrition, safety measures, psychological and cognitive well- being, and environmental health
- In-service education programs must be conducted on a regular basis to promote the knowledge, attitude and skill among the staff nurses and encourage them to participate in elderly care.

Nursing Research

- The essence of the study findings may help develop a body of knowledge about awareness on quality of life of elderly.
- Nurses and nursing students should be encouraged to undertake the research projects on quality of life of elderly patients.
- Sharing the result of the research is vital. Reports of meeting and articles in professional journals will assist in disseminating the findings.

RECOMMENDATIONS

The following recommendations are made on the basis of the present study.

- This study can be done on elderly with different settings
- Similar study with a larger sample
- Teaching programs can be adopted on a regular basis to enhance knowledge regarding the health practices of the elderly.
- The similar study can be carried out using different teaching strategies.
- A comparative study can be done with healthy elderly and elderly with any illness.

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APPENDIX-A

PERMISSION TO CONDUCT THE STUDY

Ms. Manickha Vasuki.S II year M.Sc Nursing Student conducted **"A Study To Assess The Effectiveness of Structured Teaching Program on Awareness of Quality Of Life Among Elderly Cardiac Patients at G.K.N.M Hospital, Coimbatore"** with the approval of the ethical committee during the academic year of 2013 – 2014 at G.K.N.M Hospital Coimbatore. This is the partial fulfillment of the requirement for award of the degree of Master of Science, Branch-I, Medical Surgical Nursing, sub-speciality Cardiovascular and Thoracic Nursing, by the Tamil Nadu Dr. MGR Medical University.

Dr. Ramkumar Raghupathy, M.S., M.Ch., FIAPS., MBA

DEAN

APPENDIX – B

LIST OF EXPERTS

Dr. ALKA GANESH, MD.,

HOD- Consultant Geriatric Services,

G.K.N.M Hospital,

Coimbatore- 641 037.

Dr.S.MADHAVI, Ph.D (N).,

Principal,

KMCH College of Nursing,

Coimbatore- 641 014.

Prof. RAJI.K., M.Sc (N)., Ph.D (N).,

HOD, Department of Medical Surgical Nursing,

K.G. College of Nursing,

Coimbatore- 641 018.

Prof.BEENA CHACKO, M.Sc (N)., Ph.D (N).,

HOD, Department of Fundamental Nursing,

PSG College of Nursing,

Coimbatore- 641004.

APPENDIX-C

DATA COLLECTION TOOL

Please give appropriate information to the following questions asked. The information obtained will be kept confidential and is used for the intended work.

Section A – Demographic Data **Sample No……**

1. **Age (Years)**
    a. 60 - 69
    b. 70 - 79
    c. 80 and above
2. **Sex**
    a. Male
    b. Female
3. **Education**
    a. Illiterate
    b. School level
    c. Under graduate
    d. Post graduate
4. **Occupation:**
    a. Unemployed
    b. Self employed
    c. Private employee
    d. Retired
5. **Religion:**
    a. Hindu
    b. Muslim
    c. Christian
    d. Others
6. **Marital status:**
    a. Married
    b. Single
    c. Widowed

7. **Family type**
    a. Nuclear
    b. Joint
8. **Monthly income:**
    a. Rs. 10,001 – 20,000
    b. Rs. 20,001 – 30,000
    c. Above Rs. 30,000
9. **Present Illness**
    a. Hereditary
    b. Systemic
10. **Activities of Daily Living**
    a. Independent
    b. Need some help
    c. Completely dependent
11. **Self-esteem**
    a. Self – respect
    b. Underestimate yourself
    c. Inferiority complex
12. **Family relationship**
    a. Low level
    b. Moderate level
    c. High level

Section B – The Modified WHOQOL-BREF Scale

INSTRUCTIONS:

- The following questions ask about how much you have experienced certain things in the last four weeks.
- Please give appropriate information to the following statements asked.

S.No	Item	Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you perceive your quality of life					
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very Satisfied
2.	Are you satisfied with your health					

S.No	Item	Scores				
		Not at all	A little	Sometimes	Mostly	Completely
	Physical Domain					
3	Does physical pain prevent you from doing what you need to do?					
4	Do you need any medical treatment to function in your daily life					
5	Do you have enough energy for everyday life?					
6	Are you able to mobilize yourself on a routine basis?					
7	Are you satisfied with your sleep					
8	Are you able to carry out your routine activities independently?					
9	Do you neglect any routine physical activities on a regular basis					

S. No	Item	Scores				
		Not at all	A little	Sometimes	Mostly	Completely
	Psychological Domain					
10	Do you enjoy your life?					
11	To what extent do you feel your life to be meaningful					
12	Are you able to concentrate?					
13	Are you able to accept your bodily appearance?					
14	Are you satisfied with yourself?					
15	Do you have negative feelings such as blue mood, despair, anxiety, depression					
	Social Domain					
16	Do you feel safe in your daily life					
17	How healthy is your physical environment?					
18	Do you have enough money to meet your needs					
	Environmental Domain					
19	Do you get adequate information that you need in your day-to-day life					
20	To what extent do you have the opportunity for leisure activities?					
21	Are you satisfied with the conditions of your living place					
22	Are you satisfied with your access to health services					
23	Are you happy with your transport facilities					
24	Are you happy with your personal relationships?					
25	Are you satisfied with your sex life?					
26	Are you happy with the support you get from your friends					

Scoring Criteria

Scoring	Interpretation
25 – 50	**Poor**
51 – 75	**Good**
76 – 100	**Very good**

APPENDIX-D

Topic : Awareness on Quality of Life

Group : Elderly cardiac patients

Place of teaching : Out-patient Departments and Master Health Department

Method of teaching : Lecture cum Discussion

AV Aids : Flip Chart

General Objective:

The elderly cardiac patients will acquire knowledge regarding quality of life and it will help them develop the desired attitude and skills to improve their quality of life.

Specific Objective:

At the end of the structured teaching program the subjects will be able to,

- Define Quality of Life
- List the physical activities that has to be carried out
- Enumerate the nutritional recommendations
- Explain the alternative ways to alleviate pain
- Brief about the activities taken for maintaining social, psychological, cognitive well-being

Specific objective	Content	Researcher's activity	Client's activity
Explain the ways to improve health	**Introduction:** Quality of life has become increasingly important. The influence of health status is often emphasized, but other dimensions are also important. In order to improve quality of life, there is a need to know what people themselves consider important to their perception of quality of life I am Ms.Manickha Vasuki.S II year M.Sc (N) student of G. Kuppusamy Naidu Memorial Hospital. Now I am going to discuss about the ways to improve you, for a better living. **Ways to improve health are:** Regular exercises, good nutrition, energy for everyday activities, good sleep, avoiding over the counter medications, alternative ways to alleviate bodily pain, emotional stability, Health education is a key component of most health promotion interventions, with a focus on teaching people to engage in activities that are preventive in their scope. Education addresses health practices such as nutrition, dental care, exercise and physical activity, and avoidance of smoking and environmental tobacco smoke, nutrition, dental care, and smoking cessation.	Explain by flip chart and answer subject's questions	Listens Explanations Answers

List the physical activities that has to be carried out	**Physical activity:** Physical activity is any skeletal muscle activity that causes energy expenditure. Exercise refers to structured and repetitive body movements performed with the goal of attaining physical fitness. Aerobic activity that requires the body to use oxygen to produce the energy necessary for the activity. Strength training exercises improve balance and diminishes risk for falls, strengthens musculoskeletal system, improves function and independence, decrease risk for osteoporosis, favorably modifies risk factors for cardiovascular diseases Stretching activity that improves body flexibility Health related barriers that interfere with physical activity in older adults include pain, fatigue, and sensory and mobility impairments. **Good nutrition:** The nutritional status of older adults indicate that mean daily energy intake declines by 1000 to 1200 calories in men and 600 to 800 calories in women between the ages of 20 and 80years.distribution of calories also changes, with older adults needing to consume a higher percentage of calories in carbohydrates and a lower percentage in fats, while maintaining a relatively stable protein intake of 1g\kg of body weight is recommended for older adults. The average daily intake of fiber is 10 to 1 g. fat should constitute no more than 10% to 30% of a person's daily caloric intake.	Explain by flip chart and answer subject's questions.	Listens Explanations Answers

Explain the safety precautions taken to prevent from falls Explain the ways to avoid over the counter drugs Brief about the activities taken to maintain cognitive well-being	Water is such a commonly available substance that it is often overlooked as a nutritional requirement.it is recommended that older consume 1500 to 2000ml (6 to 8 glasses) of non-caffeinated fluid daily to maintain adequate hydration. **Mobility and safety:** A nonslip foot wear should be worn when out of bed. Keep a call light reach within reach at all times. Call for help when needed. Use brightly colored stickers on the stairs to prevent from falls. Restrains have to be provided for safety. Walkers are available to improve safety and mobility. **Avoiding over the counter medications:** Carry an up-to-date list of all your medications, when your health care practitioner suggests a medication; ask if there is a way to take care of the problem without medication. Ask how long you will have to take the medication, whether the dosage can be reduced. Report any possible side-effects. A simple daily pill container can be used. The overall key intervention is to reduce the number of medications to as few as possible. **Cognitive wellness:** The following activities are effective for improving brain fitness in older adults. Engaging in new learning experiences. Carry a note pad or calendar, and use written records. Use self-instruction. Divide information into small parts that can be remembered easily. Relax and maintain a sense of humor. Give yourself time to	Explain by flip chart and answer subject's questions	Listens Explanations Answers

Enlist the alternative ways to alleviate pain Explain the methods for skin protectin	remember, forgetfulness is most likely to occur when you are in a hurry. Try to prepare in advance, when you have no time to concentrate. **Alternative Ways To Alleviate Bodily Pain** **Non-pharmacologic therapy of pain** Pain can be alleviated in elderly through the careful use of analgesic drugs combined with non-pharmacologic strategies. The non-pharmacological treatment of has been little explored and yet little used. However, these non-invasive methods can be of great help to patients suffering from pain. The association of non-pharmacologic resources with the pharmacological treatment can help reduce the use of analgesics minimizing the side effects of long term medication **Complementary and alternative therapies:** Unrelieved persistent pain commonly causes patients to seek relief with alternative medicine, including homeopathy, acupuncture, healing touch, and music therapy. **Care Of Skin** Avoid midday sun. Stay out of the sun between 10 a.m. and 4 p.m. Sunglasses and a broad-rimmed hat help, too. Cover exposed areas. Wear tightly woven, loose fitting clothing that covers as much of your skin as possible. Don't skimp on sunscreen. Use generous amounts of sunscreen when you're outdoors, and reapply often. Avoid tanning beds and sunlamps. These are just as damaging as natural sunlight	Explain by flip chart and answer subject's questions	Listens Explanations Answers

APPENDIX – F

PLAGIARISM REPORT

How does Viper work.....?

[+] Read more.. http://www.scanmyessay.com/

Plagiarism Report for ‘Vasuki Plag.docx’

Words Matched : 58

Match (%) : 1

Unique words matched : 58

Unique Match (%) : 1

Matching content : 1%

Checked on : 05-02-2014

_____ _____

Signature of the Candidate Signature of the Principal

APPENDIX-G

PHOTOGRAPHS

DATA COLLECTION

PRE-TEST

STRUCTURED TEACHING ON AWARENESS OF QUALITY OF LIFE

POST - TEST

பகுதி - அ

தனிநபர் விபரம் கீழே கேட்கப்பட்டிருக்கும் கேள்விகளுக்கு சரியான விபரம் அளிக்கவும். தங்களிடம் பெறப்பட்ட விபரங்கள் கண்டிப்பாக இரகசியமாக பாதுகாக்கப்பட்டு, ஆராய்ச்சிக்கு மட்டுமே உபயோகப்படுத்தப்படும்.

1. வயது (வருடத்தில்)

அ) 60 லிருந்து 69

ஆ) 70 லிருந்து 79

இ) 80 க்கு மேல்

2. பாலினம்

அ) ஆண்

ஆ) பெண்

3. கல்வித்தகுதி

அ) படிக்காதவர்

ஆ) பள்ளி தகுதி

இ) இளங்கலை பட்டதாரி

ஈ) முதுகலை பட்டதாரி

4. தொழில்

அ) வேலை இல்லாதவர்

ஆ) சுயதொழில்

இ) தனியார் ஊழியர்

ஈ) அரசு ஊழியர்

5. மதம்

அ) இந்து

ஆ) கிறிஸ்துவர்

இ) முஸ்லிம்

ஈ) மற்றவை

6. திருமணத்தகுதி

அ) திருமணமாகாதவர்

ஆ) திருமணமானவர்

இ) விதவை / மனைவியை இழந்தவர்

7. குடும்ப விதம்

அ) தனிக் குடும்பம்

ஆ) கூட்டுக் குடும்பம்

8. மாத வருமானம்

அ) 10,000க்கு கீழ்

ஆ)10,001 முதல் 20,000

இ) 20,001 முதல் 30,000

ஈ) 30,000 க்கு மேல்

9. குடும்ப உறவுகள்

அ) மிக நன்று

ஆ) நன்று

இ) மிககுறைவு

10. தற்போதய உடல் நோய்

அ) மரபு வழி சார்ந்தது

ஆ) உடல் மண்டல நோய்கள்

11. தினசரி வேலைகளின் தன்மை

அ) தன்னிச்சையாக

ஆ) பிறருடைய உதவி தேவை

இ) முழுவதும் பிறரை சார்ந்துள்ளது

12. சுயமரியாதை

அ) சுயமரியாதை

ஆ) முழு நம்பிக்கையில்லாமை

இ) தாழ்வு மனப்பான்மை.

பகுதி-ஆ

மாற்றத்துக்கு உட்படுத்தப்பட்ட உலகசுகாதார அமைப்பின் வாழ்க்கைதரம் பற்றிய விரிவாக்கம்

வ. எண்	பொருளடக்கம்	மிககுறைவு	குறைவு	மிககுறைவு அல்லது மிகநன்று	நன்று	மிக நன்று
1.	உங்கள் வாழ்க்கைதரம் பற்றி நீங்கள் என்ன நினைக்கிறீகள்					

		முழு மனநிறைவு அற்றது	மனநிறைவு அற்றதாக	இரண்டும் இல்லாததாக	மன நிறைவு	முழு மனநிறைவுடன்
2.	உங்கள் உடல்நலம் திருப்தியாக உள்ளதா?					

வ. எண்	பொருளடக்கம்	மதிப்பெண்				
		இல்லவே இல்லை	குறைந்தஅளவு	சிலசமயங்களில்	பெரும் பாலாக	முழுவதுமாக
3.	உங்கள் உடல்வலி நீங்கள் செய்யவேண்டிய பணிகள் செய்வதை தடுக்கிறதா?					
4.	உங்கள் தினசரி வேலைகளை செய்து கொள்வதற்கு மருந்துகளின் துணை தேவைப்படுகிறதா?					
5.	தினசரி வாழ்க்கைக்கு போதுமானஅளவு ஆற்றல் அல்லது சக்தி உங்களிடம் இருக்கிறதா?					
6.	உங்களால் தினசரி வேலைகளை செய்து கொள்ள முடிகிறதா?					
7.	உங்களின் உறக்கம் திருப்தியாக இருக்கிறதா?					

8.	உங்களின் அனுதின தேவைகளை நீங்களே பூர்த்தி செய்து கொள்கிறீர்களா?					
9.	உங்களின் அனுதினவேலைகளில் எதையாவது செய்யாமல் தள்ளி போடுகிறீர்களா?					
10.	நீங்கள் உங்கள் வாழ்க்கையை சந்தோசஷமாக அனுபவிக்கிறீர்களா?					
11.	நீங்கள் வாழ்க்கையை எந்தஅளவிற்கு அர்த்தமுள்ளதாக எண்ணுகிறீர்கள்					
12.	உங்களால் கவனம் செலுத்தமுடிகிறதா?					
13.	உங்கள் உடல் தோற்றத்தை ஏற்றுக் கொள்ள முடிகிறதா?					
14.	உங்களின் மீது உங்களுக்கு திருப்தி ஏற்படுகிறதா?					
15.	உங்களுக்கு எதிர்மறை எண்ணங்கள், அதாவது நம்பிக்கை, இழந்துபோதல், பயம், மனஅழுத்தம் ஏற்படுகிறதா?					
16.	உங்களால் உறவுமுறையில் சந்தோசஷமாக இருக்க முடிகிறதா?					
17.	உங்களின் உடல்உறவு வாழ்க்கை மனநிறைவு தருகிறதா?					
18.	உங்களுக்கு நண்பர்களின் ஆதரவு சந்தோசஷம் தருகிறதா?					
19.	நீங்கள் தினசரி வாழ்க்கை பாதுகாப்பாக உள்ளது என்று உணர்கிறீர்களா?					
20.	உங்கள் சுற்றுபுறசுழல் நலமானதாகஉள்ளதா?					
21.	உங்களுடைய தேவைகளை பூர்த்தி செய்துகொள்ள உங்களிடம் பணவசதி உள்ளதா?					
22.	உங்களுடைய அன்றாட வாழ்க்கைக்கு தேவையான தகவல்கள் போதுமான அளவு கிடைக்கிறதா?					
23.	உங்கள் பொழுதுபோக்குக்கு எந்த அளவில் வாய்ப்புகள் கிடைக்கிறது?					
24.	நீங்கள் வாழும்இடம் உங்களுக்கு நிம்மதியை தருகிறதா?					
25.	மருத்துவ சேவைகள் உங்களுக்கு கிடைப்பது எளிதாக உள்ளதா?					
26.	உங்களுக்கு வாகனவசதி திருப்திகரமாக இருக்கிறதா?					

தலைப்பு : வாழ்க்கை தரம் பற்றிய விழிப்புணர்வு

குழு : வயதான இதயநோயாளிகள்

இடம் : வெளிநொயாளிகள் பிரிவு மற்றும் முழுஉடல் பரிசோதனை பிரிவு

கற்பிக்கும் முறை : விரிவுரைத்தல் மற்றும் கலந்தாலோசித்தல்

கற்பிக்க உதவும் சாதனம் : படங்கள் அடங்கிய மடக்கு அட்டை பொதுவான குறிக்கோள் கற்பித்தலின் முடிவில் வயது மதிர்ந்த இதயநோயாளிகள் வாழ்க்கைதரம் குறித்த அறிவை பெற முடியும் மற்றும் அது அவர்களுக்கு வாழ்க்கைதரத்தை மேம்படுத்த தேவையான அணுகுமுறை மற்றும் திறன்களை வளர்க்க உதவும்.

முக்கிய குறிக்கோள்கள்

கட்டமைக்கப்பட்ட கற்பிக்கும் திட்டத்தின் இறுதியில் முதியவர்கள்

- சுகாதாரத்தை மேம்படுத்தும் வழிகளை விளக்குதல்
- மேற்கொள்ளப்பட வேண்டிய உடல் செயல்பாடுகளை பட்டியலிடுதல்
- ஊட்டச்சத்து பரிந்துரைகள் பற்றி பட்டியலிடுதல்
- வலியை போக்கும் மாற்றுவழிகளை விளக்குதல்
- சமூக உளவியல் மற்றும் அறிவாற்றல் நலவாழ்வை பராமரிக்க எடுக்க வேண்டிய நடவடிக்கைகள் பற்றி சுருக்கமாக விவரித்தல்.

முக்கிய குறிக்கோள்	பொருளடக்கம்	ஆசிரியரின் செயல்திறன்	பயிலுவோரின் செயல்திறன்
	முன்னுரை: வாழ்க்கைதரம் என்பது முக்கியமான ஒன்றாக மாறிவிட்டது. இதில் உடல்நிலை அடிக்கடி வலியுறுத்தப்படுகிறது. ஆனாலும் மற்ற பரிமாணங்களும் முக்கியமானவை. வாழ்க்கை தரத்தை மேம்படுத்தும் பொருட்டு, வாழ்க்கைதரத்தை பற்றிய தங்கள் கருத்தில் மக்கள் எதை முக்கியமானதாக எண்ணுகிறார்கள் என்பதைப்பற்றி தெரிந்து கொள்ளவேண்டியது அவசியம். எனது பெயர் செல்வி.மாணிக்க வாசுகி. நான் ஜி.குப்புசாமி நாயுடு நினைவு மருத்துவமனையில் இரண்டாம் ஆண்டு எம்.எஸ்.சி (நர்சிங்) படிக்கும் மாணவி. இப்போது நான் ஒரு நல்ல வாழ்க்கையை நீங்கள் மேம்படுத்தும் வழிகளை பற்றி விவாதிக்க உள்ளேன்.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்
சுகாதாரத்தை மேம்படுத்தும் வழிகளை விளக்குதல்	சுகாதாரத்தை மேம்படுத்தும் வழிகள் : உடல்நலத்தை மேம்படுத்தும் வழிகள் : வழக்கமான உடற்பயிற்சிகள், நல்ல ஊட்டசத்து, அன்றாட நடவடிக்கைகளுக்கான ஆற்றல், நல்லதூக்கம், மருத்துவர் பரிந்துரை செய்யாத மருந்துகளை உட்கொள்வதை தவிர்த்தல், உடல் வலியை போக்க மாற்று வழிகள், உணர்ச்சி ஸ்திரத்தன்மை மற்றும் தோல் பராமரிப்பு. சுகாதார கல்வி சுகாதாரத்தை மேம்படுத்துவதில் முக்கிய அங்கம் வகிக்கிறது. எப்படியென்றால் சுய கவனிப்பு நடவடிக்கைகளில் மக்கள் தங்களை ஈடுபடுத்த கற்று கொள்வதன் முலமாக.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

	இந்த கல்வி, சுகாதார நடைமுறைகளான ஊட்டசத்து, பல் பாதுகாப்பு, உடற்பயிற்சி மற்றும் உடல்செயல்பாடு புகைபிடிப்பதை தவிர்த்தல் மற்றும் சுற்றுசூழல் புகையிலை புகையை தவிர்த்தல் மற்றும் மனரீதியான சுகாதாரம்.		
மேற்கொள்ளப்பட வேண்டிய உடல் செயல்பாடுகளை பட்டியலிடுதல்	உடல் செயல்பாடு: உடல் செயல்பாடு என்பது ஆற்றல்செலவு ஏற்படுத்தும் எலும்பு தசை செயல்பாடு ஆகும். உடற்பயிற்சி என்பது உடற்தகுதியை பெறும் இலக்கோடு கட்டமைக்கப்பட்ட மற்றும் மீண்டும் செய்யும் உடல் அசைவுகள் ஆகும். ஏரோபிக் செயல்பாடு என்பது உடலிலிருக்கும் பிராணவாயுவை உபயோகப்படுத்தி உடல்செயல்பாட்டிற்கு தேவையான ஆற்றலை உற்பத்தி செய்கிறது. வலிமை பயிற்சி சமநிலையை மேம்படுத்தி கீழே விழுவதற்கான ஆபத்தை குறைக்கிறது. தசை எலும்பு கூட்டு அமைப்பை உறுதிப்படுத்துகிறது.செயல்பாடு மற்றும் சுதந்திரத்தை அதிகரிக்கிறது. எலும்புத்துளை நோயின் ஆபத்தை குறைக்கிறது மற்றும் இதய நோய்களுக்கான ஆபத்துக் காரணிகளை மாற்றி அமைக்கிறது. நீட்டும் பயிற்சிகள் உடல் வளைந்துக் கொடுப்பதை அதிகரிக்கிறது. வயதானவர்களின் உடல் செயல்பாட்டில் தலையிடும் சுகாதாரம் சம்பந்தமான தடைகளாவன: வலி, சோர்வு மற்றும் உணர்ச்சி மற்றும் இயகக் குறைபாடுகள் நல்ல ஊட்டச்சத்து: வயது முதிர்ந்தவர்களின் ஊட்டச்சத்து நிலை 20 முதல் 80 வயது வரை உள்ள ஆண்களில் 1000 முதல் 1200 கலோரி அளவு மற்றும் பெண்களில் 600 முதல் 800 கலோரி அளவு தினசரி	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

முக்கிய குறிக்கோள்	பொருளடக்கம்	ஆசிரியரின் செயல்திறன்	பயிலுவோரின் செயல்திறன்
	ஆற்றல் உள்ளெடுக்குக்கும் அளவிலிருந்து குறைவதை குறிக்கிறது. வயது முதிர்ந்தவர்கள் உட்கொள்ள வேண்டிய கலோரி வீதம் : அதிக சதவீத கலோரி மாவுச்சத்து மூலமாகவும், குறைந்த சதவீத கலோரி கொழுப்புச்சத்து மூலமாகவும் 1 கிலோ உடல் எடைக்கு ஒரு கிராம் புரதச்சத்து உட்கொள்வது என பரிந்துரை செய்யப்பட்டுள்ளது. ஒரு கிராம் முதல் 10கிராம் வரைக்கும் தினசரி நார்சத்துள்ள உணவுகளை உட்கொள்ளவேண்டும். நீர் பொதுவாக கிடைக்கக்கூடியதாக இருந்தாலும், ஊட்டச்சத்து ஆதவைகளில் ஒன்றாக கருதப்படுகிறது. வயது முதிர்ந்தவர்கள் 1500 முதல் 2000 மி.லி வரை க/பேன் அல்லாத திரவம் தினசரி உட்கொள்ளவேண்டும் என பரிந்துரை செய்யப்பட்டுள்ளது.		
கீழே விழுவதை தடுப்பதற்கான பாதுகாப்பு முன்னெச்சரிக்கைகளை விளக்குதல்	இயக்கம் மற்றும் பாதுகாப்பு : படுக்கையை விட்ட வெளியே வரும்போது வழுக்காத பாதஅணிகளை அணியவேண்டும். எல்லா நேரங்களிலும் ஒளிவிளக்கு கைக்கு எட்டும் தூரத்தில் வைத்துக் கொள்ளவேண்டும். உதவி தேவைப்பட்டால் அழைக்கவேண்டும். கீழே விழுவதை தடுப்பதற்காக மின்விளக்குடன் படிகள் படிகள்,கைத்தடி, களியல் அறையில் கைப்பிடி, கட்டில் தடுப்பு மற்றும் வழுக்காத மிதியடி போன்றவற்றை உபயோகப்படுத்தவேண்டும். இயக்கம் மற்றும் பாதுகாப்பை மேம்படுத்த நடைபயிற்சி சாதனம் இருக்கிறது.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

மருத்துவரின் ஆலோசனை இல்லாமல் மருந்து உட்கொள்வதை தவிர்ப்பது பற்றி விளக்குதல்	**மருத்துவரின் ஆலோசனை இல்லாமல் மருந்து உட்கொள்வதை தவிர்த்தல் :** உங்கள் சுகாதார பயிற்சியாளர் ஒரு மருந்தை பரிந்துரை செய்யும்போது உங்களிடம் இருக்கும் அனைத்து மருந்துகளையும் தேதி பட்டியலோடு எடுத்துச் செல்லுங்கள். மருந்து உட்கொள்ளாமல் அந்த பிசைச்சனையை தீர்க்க வழி இருக்கிறதா என்று கேளுங்கள். எவ்வளவு காலம் மருந்து எடுத்துக் கொள்ளவேண்டும் என்பதையும், மருந்தின் அளவை குறைக்க முடியுமா என்பதையும் கேளுங்கள். பக்கவிளைவுகள் ஏற்பட்டால் உடனே தெரிவிக்கவும். ஒரு எளிய தினசரி மாத்திரை கொள்கலன் பயன்படுத்துங்கள். ஒட்டமொத்த முக்கிய தலையீடு என்னவென்றால் முடிந்தவரை மருந்துகளின் எண்ணிக்கையை குறைப்பது ஆகும்.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

அறிவாற்றல் நல்வாழ்வை பராமரிக்க எடுக்க வேண்டிய நடவடிக்கைகள் பற்றி சுருக்கமாக விளக்குதல்	**அறிவாற்றலில் ஆரோக்கியம் :** பின்வரும் நடவடிக்கைகள் வயது முதிர்ந்தவர்களின் மூளையின் ஆற்றலை மேம்படுத்த பயனுள்ளதாக இருக்கும். ☐ புதிய கற்றுக்கொள்ளும் அனுபவங்களில் ஈடுபடுதல் ☐ ஒரு குறிப்பு அட்டை மற்றும் நாள்காட்டி எடுத்தச்செல்லுதல் மற்றும் எழுதப்பட்ட பதிவேடுகளை உபயோகப்படுத்துவது. ☐ எளிதில் நினைவில் வைத்துக் கொள்ள கூடிய விதத்தில் தகவல்களை சிறிய பகுதிகளாக பிரித்து வைத்தல். ☐ ஓய்வு மற்றும் நகைச்சுவை உணர்வை தக்கவைத்துக் கொள்ளுங்கள் ☐ ஞாபகப்படுத்திக் கொள்ள நேரம் கொடுங்கள் ஏனென்றால் நீங்கள் அவசரப்படும்போது ஞாபகமறதி ஏற்படம் வாய்ப்பு அதிகம் உள்ளது ☐ நீங்கள் கவனம் செலுத்துவதற்கு நேரம் இல்லை என்றால் முன்கூட்டியே தயார் செய்ய முயற்சி எடுங்கள்	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

உடல்வலியை போக்க மாற்றுவழிகள் பற்றி பட்டியலிடுதல்	**உடல்வழியை போக்க மாற்றுவழிகள்:** வலிக்கான மருந்தியல் அல்லாத சிகிச்சைமுறை: முதியவர்களின் வலியை போக்குவதற்கு வலிநிவாரணி மருந்துகளுடன் இணைந்து மருந்தியல் அல்லாத உத்திகளை பயன்படுத்தலாம். மருந்தியல் அல்லாத சிகிச்சைமுறை சிறிய அளவில் மட்டுமே ஆராயப்பட்டு பயன்படுத்தப்பட்டு வருகிறது. இந்த வளங்களை பயன்படுத்த ஆதரவு இல்லாததால் அது வலி சிகிச்சைக்கான பயனுள்ள கருவிகளாக செயல்படுவதற்கு இடையூராக உள்ளது. எனினும் துளைத்தல் அல்லாத இந்த முறைகள் வலியினால் பாதிக்கப்படும் நோயாளிகளுக்கு பெரும் உதவியாக இருக்கும். மருந்தியல் அல்லாத வளங்கள் மற்றும் மருந்தியல் சிகிச்சைமுறையை இணைப்பதால் வலிநிவாரணிகள் பயன்படுதுவதை குறைத்து மருந்துகளின் நீண்டகால பக்க விளைவுகளையும் குறைக்கிறது. உடல்ரீதியான சிகிச்சைகள்: உடற்பயிற்சி மருத்துவரின் முதன்மையான பங்கு நிபுணர்களின் கருத்துக்களால் வரையறுக்கப்படுகிறது. ஆனால் தரமான சான்றுகள் ஏதும் இல்லை. வாழ்க்கைத்தரத்தின் செயல்பாட்டுகூறு மற்றும் வலியிலுள்ள குறிப்பிடதக்க முன்னேற்றங்களின் பராமரிப்பு அல்லது முன்னேற்றம், மேம்படுத்தப்பட்ட உடற்பயிற்சி நேர நிலைகள் மற்றும் வளங்களை பெற்ற நோயாளிகளால் குறிப்பிடப்பட்டுள்ளது.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்

சரும பாதுகாப்பு முறைகள் பற்றி விளக்குதல்	**சரும பாதுகாப்பு :** சூரியனிடமிருந்த உங்களை பாதுகாத்துக் கொள்ளுங்கள். நண்பகல் சூரியனை தவிர்க்கவேண்டும். காலை 10 மணியிலிருந்து மாலை 4 மணிவரை சூரிய வெளிச்சத்தை தவிர்க்கவும். கறுப்பு கண்ணாடிகள் மற்றும் பரந்த விளிம்பு உள்ள தொப்பிகள் இதற்கு மிகவும் உதவுகிறது. வெள்யே தெரியும் உடல்பகுதிகளை மூடி வையுங்கள். முடிந்தவரை உங்கள் தோலை மூடுவதற்கு இறுக்கமாக பிணைக்கப்பட்ட மற்றும் தளர்வான ஆடைகளை அணியவேண்டும். கூரிய ஓளியிலிருந்து பாதுகாக்கும் உடலில் பூசும் திரவங்களை வெளியே செல்லும்போது தாராளமான அளவு மற்றும் அடிக்கடி பயன்படுத்த வேண்டும். தோல் பதனிடப்பட்ட படுக்கைகள் மற்றும் சூரிய விளக்குகளை தவிர்க்கவேண்டும். ஏனெனில் இவை இயற்கையான சூரிய ஓளியைப்போல் பாதிப்பை ஏற்படுத்தகூடியவை.	படங்கள் அடங்கிய மடக்கு அட்டை மூலம் விளக்குதல்	கவனித்தல் மற்றும் புரிந்து கொள்ளுதல்